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The Relationship Between Co-Dependence and Borderline Personality Disorder

Helen P. Bird
Andrews University

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Andrews University

School of Education

THE RELATIONSHIP BETWEEN CO-DEPENDENCE AND BORDERLINE PERSONALITY DISORDER

A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Helen P. Bird

April 1996

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APPROVAL BY THE COMMITTEE:

Chair: James A. Tucker

Director, Graduate Programs
Jerome D. Thayer

Member: William H. Green

Dean, School of Education

Member: Nancy J. Carbonell

External: James J. North

May 5, 1996
Date approved

ABSTRACT

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by

Helen P. Bird

Chair: James A. Tucker

ABSTRACT OF GRADUATE STUDENT RESEARCH

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Title: THE RELATIONSHIP BETWEEN CO-DEPENDENCE AND BORDERLINE PERSONALITY DISORDER

Name of researcher: Helen P. Bird

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Problem

Co-dependence (CODC) is described as an "incurable disease" by some practitioners in the addictions treatment business. The CODC concept developed in isolation from mainstream psychology and psychiatry and remains an unverified diagnostic category. It has been compared with Borderline Personality Disorder (BPD) and this relationship was investigated.

Method

Representative samples of the voluminous literature on CODC and BPD were reviewed in an effort to identify

commonalities. The characteristics used for comparison were the ones identified by Dr. E. G. Goldstein in *Borderline Disorders: Clinical Models & Techniques* (1990). Two self-report, anonymous instruments were used; one was completed by clinicians and the other by persons who self-identify as co-dependent or were so identified by a relative, friend, or counselor.

Results

Evidence of commonalities between CODC and BPD was provided by an exacting comparison of descriptions from both bodies of literature. In addition, the survey of clinicians revealed insufficient understanding of the nature and characteristics of BPD and CODC that could lead to a failure to diagnose accurately. The survey of clients provided rich evidence that many persons identified as co-dependent obtained scores on a BPD instrument higher than required to be suggestive of a diagnosis of BPD.

Conclusions

There appears to be an area of overlap between CODC and BPD. Clinicians are not taught to recognize this overlap but when they are tested on a BPD instrument, "co-dependent" persons often endorse enough items to be suggestive of a BPD diagnosis.

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ACKNOWLEDGMENTS

I dedicate this to God: Father, Son, and Holy Spirit, whose love and Word sustain me. "Blessed be the Lord, who daily loadeth us with benefits," Ps 68:19, KJV.

I am especially grateful for the support of: David Kennedy Bird, my beloved son; Dr. Darwin Dorr, my mentor, who confirmed the ideas presented here and guided me through several critical stages; Dr. Eda Goldstein, for permission to use her list of BPD characteristics to organize the data comparing CODC and BPD; Dr. James Tucker, Chair of my dissertation committee; Dr. Nancy Carbonell and Dr. William Green, committee members; Dr. James North, External; Dr. Jerome Thayer, Program Director; Bonnie Proctor, Dissertation Secretary; Dr. Elsie Jackson, our Department Chair; Dr. Hope Conte, Dr. Vincent Dummer, Kentucky Psychological Association, Baptist Regional Hospital, and Kentucky River Community Care, for their gracious assistance with the two anonymous surveys; and Dr. Cherryl Galley and Dr. Penny Webster, classmates and dear friends, for their prayers, encouragement, and steadfast support.

CHAPTER 1

PURPOSE OF THE STUDY

The purpose of this qualitative study was to determine whether Co-dependence (CODC) and Borderline Personality Disorder (BPD) are separate entities or whether their characteristics overlap as they are described in the pop-psychology and clinical literature respectively, and as they are perceived by clinicians and clients.

Introduction

CODC was conceptualized in addictions treatment centers when certain characteristics were found in family members of the addicted persons, initially alcoholics. This was the result of treatment centers extending their services to relatives of the identified patients. The meaning of the term "co-dependent" was later expanded to include the relatives and friends of persons with any addiction, not just alcoholism, and often the addicted person as well. In my preliminary research of CODC I noticed that two authors who were prominent in that field, John Bradshaw (1988) and Timmen Cermak (1986a), had compared CODC to BPD.

An argument could be made for comparing CODC with several personality disorders. The characteristics used to

describe CODC are similar to the characteristics used to describe Cluster B and Cluster C personality disorders. Cluster B includes persons who often appear dramatic, emotional, or erratic. Cluster B consists of borderline, antisocial, narcissistic, and histrionic personality disorders. Co-dependent people also may have some of the characteristics of the Cluster C personality disorders, which include persons who often appear anxious or fearful. Cluster C consists of dependent, avoidant, obsessive-compulsive, and passive-aggressive personality disorders.

Two factors led me to limit my research to BPD. One was the fact that Cermak and Bradshaw had compared CODC to BPD, specifically. The other was my own observation that some of my friends and clients who identified themselves as co-dependent did appear to have characteristics of BPD. Therefore, I decided to explore the question of whether the characteristics of CODC overlap the characteristics of BPD.

Overview of the Problem

The very existence of co-dependence is an area of increasing controversy. Authorities in the field cannot even agree on how to spell it. The term is spelled both with and without a hyphen, depending on which author you are reading. For this dissertation I use the hyphenated spelling except in some quotations. At the present time (February 1996) CODC remains an unverified diagnostic

entity. After thorough study, it was deliberately excluded from DSM-IV, and it has been challenged by mental health professionals both inside and outside of the addictions treatment business (Fulton & Yates, 1990; Gomberg, 1989; Haaken, 1990, 1993; Harper & Capdevila, 1990; Hibbard, 1993; Kaminer, 1993; Katz & Liu, 1991; Oliver-Diaz & O'Gorman, 1989; Peele, 1989; Peele & Brodsky, 1991; Van-Wormer, 1989).

Even among its adherents there has been no agreement on defining CODC. Subby and Friel (1984, p. 32) define co-dependency as "a dysfunctional pattern of living and problem-solving which is nurtured by a set of rules within the family system. These rules make healthy growth and change very difficult." They list 11 common characteristics of co-dependency including: difficulty identifying feelings, difficulty expressing feelings, difficulty forming or maintaining close relationships, perfectionism, rigid attitudes and behavior, difficulty adjusting to change, feeling overly responsible for other people's behavior or feelings, constant need for other's approval, difficulty making decisions, feeling powerless over one's life, and a basic sense of shame and low self-esteem.

Others describe CODC as including ambivalence, anger, rigidity in attitudes and behavior, shame and low self-esteem, impulsivity, the need to control others, avoidance of conflict, difficulty identifying and expressing one's own feelings, need for the approval of others,

perfectionism, preoccupation with relationships, and a high tolerance for inappropriate behavior (Beattie, 1987; Black, 1981; Bradshaw, 1988; Cermak, 1986a; Gravitz & Bowden, 1985; Health Communications, 1984; Larsen, 1985; Mellody, 1989; Schaef, 1986; Subby, 1987; Wegscheider-Cruse, 1987; Woititz, 1985). Katz and Liu (1991) suggest that such lists represent a theory that is so broad it is virtually meaningless.

In 1989 some of the leading spokespersons in the field of CODC agreed upon the following definition: "Co-dependency is a pattern of painful dependency on compulsive behaviors and on approval from others in an attempt to find safety, self-worth and identity" (Meacham, 1989, p. 3).

In *Co-Dependence Misunderstood--Mistreated*, Schaef (1986, pp. 16-17) quotes Charles Whitfield, M.D., as follows: CODC is "ill health, or maladaptive or problematic behavior that is associated with living, working with, or otherwise being close to a person with alcoholism," and he says that "it [co-dependence] affects not only individuals, but families, communities, businesses and other institutions, and states and countries."

A glance at the shelves in the self-help section of a book store will reveal that books on "co-dependence" are interspersed with books on "adult children of alcoholics"

(ACOA). In fact, much of the literature on CODC uses those two terms synonymously. One might say that CODC is what one "has" and an ACOA is one category of person who "has" it. In fact, Haaken (1990, p. 396) says the ACOA is the "prototypical" codependent. But it can get very complicated, as Dr. Stephanie Brown explains:

> While codependents are most often thought to be the nonalcoholic partner or child, the alcoholic also can be a codependent to someone else's alcoholism. For example, *both* parents may be alcoholics and, therefore, both codependents as well. Alternatively, the ACA [adult child of an alcoholic] may be a codependent in relation to the alcoholic parent and an alcoholic him or herself. (Brown, 1988, p. 59)

Psychiatrist Timmen Cermak (1986a) notes that when the distance between the co-dependent and another person changes, the co-dependent may display intense BPD characteristics. He observes that there may be rapid swings when one sees "one's partner as all good or all bad as the co-dependent lurches back and forth between feeling totally inadequate and feeling in control of matters." As the individual's black-and-white thinking increases, Cermak says the co-dependent's world becomes fractured or split into "friends" and "enemies." According to Cermak, "friends" are the people who support the co-dependent person's denial. "Friends" commiserate with the co-dependent person's pain; those "friends" often are idealized. "Enemies" are the people who insist on speaking the truth; "enemies" may become the target of the co-dependent person's intense rage

(Cermak, 1986a, p. 19).

Cermak observes that the anxiety that is created in the person "by changing interpersonal distance can spiral into fear of abandonment or of being overwhelmed by intimacy" (1986a, p. 19). Cermak believes these factors contribute to relationships being especially problematic for co-dependents.

Gomberg (1989) noted that the same issue of the *Journal of Psychoactive Drugs* that carried an article by Timmen Cermak, M.D,. on his proposed diagnostic criteria for co-dependence (see Appendix A) also contained a critical review of the concept of "co-dependency" by Gierymski and Williams (1986). Gomberg (1989, pp. 123-124) observed that these authors, who were affiliated with the Hazelden Foundation, a pioneering and highly respected addictions treatment facility in Minnesota, "described 'codependency' as being used to diagnose '. . . a primary disease (and) a treatable diagnostic entity,' in spite of the fact that it was a concept not based on data but rather on intuition, assertion and anecdotes."

Meanwhile, clinicians were beginning to see clients whose needs had not been met by the resources available to persons who perceived themselves as "co-dependent." Dr. Stan J. Katz, a clinical psychologist, (Katz & Liu, 1991) reported that in recent years he had seen a "marked increase" in the number of his patients who were "veterans"

of self-help groups such as the various Twelve Step or "Anonymous" organizations which, he says, entice people with "reassurance, acceptance, and validation" but offer few real solutions. (Note: I use the terms "patient" and "client" interchangeably in this dissertation.) Dr. Katz says he has found that those programs promote dependence, not recovery. He says his experience with this population has shown him that the normal resilience of some individuals "is undermined by self-help programs that teach members to view themselves as powerless and disease-ridden, by 'recovery experts' who maintain that virtually our entire society requires lifetime treatment" (Katz & Liu, 1991, p. xiii). (For a list of the "Twelve Steps of Alcoholics Anonymous," on which these groups are patterned, see Appendix D.)

In her widely cited study funded by a grant from the National Institute on Alcohol Abuse and Alcoholism, Gomberg (1989, p. 118) found that "there are *no* data at all which justify diagnosing family members in any family in which substance abuse occurs, as manifesting personality disorder solely on the basis of their family membership."

Research such as that done by Gierymski and Williams (1986) was conducted in response to assertions by CODC clinicians like Sharon Wegscheider-Cruse (1984, p. 2), who stated that "co-dependency is a primary disease and a disease within every member of an alcoholic family."

Gierymski and Williams (1986) concluded that while

family members in alcoholic families may have more and a greater variety of emotional problems than do comparable family members in families that are not alcoholic, they did not find a clear-cut clinical entity that corresponded to co-dependency. Gomberg (1989, p. 124) noted that shortly after the article by Gierymski and Williams appeared, the Hazelden Foundation announced (Professional Update, 1987) that it would no longer use the diagnosis of co-dependency.

On the other hand, there has been increasingly greater acceptance of the BPD diagnosis. (For lists of the criteria of BPD in DSM-III-R and DSM-IV, see Appendices B and C, respectively.) Speakers at the "Highlights of the DSM-IV" simulcast on June 4, 1994 (APA and NCSPPP, 1994), said BPD will be included in "Mental and Behavioural Disorders," Chapter 5, of the *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision (ICD-10). ICD-10 will be published within the next few years by the World Health Organization (WHO). Like its predecessors, ICD-10 will be the worldwide standard for medical diagnosis.

In many addictions treatment settings a person with the characteristics described above would be called a "co-dependent." However, if that person were being seen by a mental health professional for his or her own issues in a mental health setting, the characteristics that were described as "co-dependence" might now be used to diagnose

the client as having a Borderline Personality Disorder.

There are several interesting problems: The people who buy CODC literature and attend CODC lectures and support groups believe *something* is wrong with them. What is CODC? Whatever it is, it seems to have been overlooked by practicing clinicians. Why? Was it overlooked because it is a variation of something else? Could it be related to BPD? If so, it would be interesting to see how co-dependent persons would score on a BPD instrument. These concerns are summarized in the following research questions.

Research Questions

Question 1: Is there an area of overlap between what pop-psychology calls CODC and the clinical literature calls BPD?

Question 2: If there is some overlap of CODC and BPD, is the overlap recognized by practicing clinicians?

Question 3: How would co-dependent persons score on a BPD test instrument?

Importance of the Study

CODC was popularized in the 1980s and expanded from its base in alcoholism treatment centers to become a major portion of the mass market self-help pop-psychology literature business. Because of the continuing popularity of this subject many people who now present themselves for therapy in psychologists' offices describe themselves as

being "co-dependent," *and expect us to know what that means.*

As ethical and responsible clinicians, we have an obligation to educate ourselves on this topic. The possibility of verifying whether there was overlap of the characteristics that one group called CODC and another group called BPD appeared to present an opportunity for me to make a contribution to my profession.

Assumptions

The following assumptions were made for the purposes of this study:

1. Archival research of the literature can provide evidence of similarity or dissimilarity of CODC and BPD.

2. The subjects who participate in the voluntary, anonymous surveys would understand the instructions of the instruments and would possess the appropriate reading and writing skills necessary to respond.

3. The subjects who participate in the voluntary, anonymous surveys would provide honest responses.

Definition of Terms

The following terms used in this study are defined as follows:

Adult Child of Alcoholic (ACOA). An ACOA is a person who is now an adult but grew up in a home where alcoholism was present.

Al-Anon. Al-Anon is a support group for persons who

are in relationships with alcoholics. The program is based on the Twelve Steps of Alcoholics Anonymous. People who attend the meetings identify themselves only by their first names (or not at all) in order to maintain anonymity.

Borderline Personality Disorder. The essential feature of BPD is "a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts" (APA, 1994, p. 650).

Co-dependence or co-dependency. The definition depends on which author you are reading; several definitions have been presented in this text. At a conference in 1989, some spokespersons in the field of CODC agreed upon the following definition: "Co-dependency is a pattern of painful dependency on compulsive behaviors and on approval from others in an attempt to find safety, self-worth and identity" (Meacham, 1989, p. 3).

Co-dependent. Again, this can mean many things, depending on which author you are reading. In this study I use a composite: Co-dependents are persons who were raised or now live in an alcoholic family, who describe themselves as co-dependent, or who are considered to be co-dependent by another person such as a relative, friend, or counselor and may or may not agree with that opinion.

Twelve Steps or Twelve Step Groups. This refers to the Twelve Steps of Alcoholics Anonymous (see Appendix D).

A Twelve Step Group is any of the numerous kinds of support groups (eating, gambling, etc.) based on the Twelve Steps.

Sources of Data

The conclusions drawn from this research were based on data obtained from three sources. First, the primary documentary evidence is a presentation of characteristics common to BPD and CODC. It was distilled from the reviews of literature, supplemented with additional quotations, and organized in a rational sequence using the categories from E. G. Goldstein's *Borderline Disorders: Clinical Models and Techniques* (1990). Second, a survey was completed by clinicians, and third, a survey was completed by clients.

1. Characteristics common to BPD and CODC: The "backbone" of this dissertation, the skeletal structure or schema which I created to bring some order to the BPD and CODC literature, is a listing of the characteristics common to BPD and CODC. Because this came first and was the basis for all that followed, it is referred to as the primary documentary evidence. This consists of a graphic rendering of parallel quotations from the CODC and BPD literature. The word graphic, as used here, is defined as "1. Describing or described in realistic and vivid detail; vivid; lifelike" (*Webster's*, 1968, p. 795).

The material in chapter 6 was distilled from the more comprehensive reviews of both bodies of literature in

chapters 4 and 5, supplemented by an extensive amount of additional quotations.

Chapter 6 consists of a side-by-side presentation of descriptions by recognized authorities in the fields of CODC and BPD articulating the characteristics that one body of literature says is diagnostic of BPD and what another body of literature says is "diagnostic" of CODC. This format was created after hundreds of hours of struggling to locate and understand the vague descriptions of CODC and compare them with what appeared to be parallel clinical descriptions of the characteristics of BPD.

2. Clinician survey: I created an anonymous survey for clinicians to determine what *they believe* (not what the criteria say) are characteristics of CODC and of BPD, and whether they believe any characteristics of the two overlap. My one-page self-report instrument was devised specifically for this purpose. The 10 items on the instrument are all quotations from recognized BPD authorities such as Eda G. Goldstein, Ph.D., John Gunderson, M.D., Otto F. Kernberg, M.D., and James F. Masterson, M.D., so whenever the CODC column is checked it is an automatic endorsement of a BPD characteristic.

3. Client survey: For this dissertation the author of the Borderline Syndrome Index granted me permission to call it the Anonymous Personality Style Inventory. It was completed voluntarily and anonymously by clients who

identified themselves as co-dependent or who were considered to be co-dependent by someone else such as a relative, friend, or counselor and who may or may not have agreed with that opinion. Cooperation in this endeavor was obtained from a regional hospital in Corbin, Kentucky, and community mental health centers in Hazard and Jackson, Kentucky, that offer services to the co-dependent population.

Outline of the Study

This qualitative dissertation is organized into eight chapters. Chapter 1 is an introduction, which includes the purpose of the study, an overview of the problem, the three research questions, the importance of the study, assumptions, definitions, and sources of data. Chapter 2 is a review of the CODC literature. Chapter 3 is a review of the BPD literature. Chapter 4 discusses similarities between CODC and BPD. Chapter 5 presents the methodology in greater detail. Chapter 6 presents the primary documentary evidence, a detailed side-by-side presentation of quotations by authorities in the two fields of characteristics that are common to BPD and CODC. Chapter 7 presents the secondary supporting evidence from the anonymous survey of clinicians and the anonymous survey of clients, and chapter 8 presents conclusions, briefly summarizes what was done, and provides recommendations for practice and for further study.

CHAPTER 2

REVIEW OF CO-DEPENDENCE LITERATURE

Introduction

Though numerous practitioners in the substance abuse treatment business have been treating co-dependence as well as writing and lecturing on it for many years, only recently was agreement reached on a definition of the term "co-dependent." This is similar to the multitude of opinions on the nature and defining characteristics of BPD.

At the First National Conference on Co-Dependency, in September 1989, a panel of experts in the family, addictions, and mental health fields spent 5 hours hammering out a definition of the term. As noted earlier, they finally agreed that "co-dependency is a pattern of painful dependency on compulsive behaviors and on approval from others in an attempt to find safety, self-worth and identity" (Meacham, 1989, p. 3).

The concept of CODC originated in alcoholism treatment centers when the distinctive, predictable behavior patterns described previously were observed in members of the alcoholic's family (Cermak, 1986a; Cleveland, 1987).

Before the advent of dual diagnosis programs there was very little interchange of data between the realm of alcohol treatment and the mental health professions (Schaef, 1986; Vannicelli, 1989, p. xi). Indeed, in June 1991 a computer search of PsycLIT for the term "codependence" yielded only 35 references. And James P. Morgan, Jr. (1991, p. 721) noted that 11 of those articles were in a special issue of *Alcoholism Treatment Quarterly* devoted to "Codependency: Issues in Treatment and Recovery," edited by Carruth and Mendenhall (1989). In the remaining 24 citations the term was often used in the sense of "things that occur together," not in the sense in which it is used in this study.

Origin of the CODC Construct

It is significant to note that the CODC concept developed in treatment settings that were staffed mainly by persons at the bachelor or master's degree level, or who had no academic degree at all and were not trained in scholarship or research. In those treatment settings the concept was not subjected to the rigorous scrutiny of clinicians who had been trained in the research techniques and methodologies required of doctoral-level psychologists.

CODC was conceptualized in addictions treatment centers when certain characteristics were found in family members of the addicted persons, initially alcoholics. This

was the result of treatment centers extending their services to relatives of the identified patients. The meaning of the term "codependent" was later expanded to include the relatives and friends of persons with any addiction, not just alcoholism, and often the addicted person as well.

Many of the para-professionals who treat CODC in quasi-professional settings, such as the "family" or CODC programs of addiction treatment centers, have their job largely *because* they have been addicts themselves (Harper & Capdevila, 1990, p. 289; Kaminer, 1993; Katz & Liu, 1991). Their "degree" may be something like C.A.C., which stands for certified addiction counselor. It is not an academic degree.

According to their brochures for 1988-89, Oaklawn Hospital (1988), a midwestern psychiatric hospital fully accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), offered a 1-year training program for the certification of addiction treatment counselors that required only 96 clock hours of training, much of it taught by bachelor or master's-level instructors.

Extraordinary Claims About CODC

Cermak (1986a, p. vii) says "most descriptions of co-dependence have been anecdotal or metaphoric, and neither anecdote nor metaphor stands up well under scientific scrutiny." In addition to actual stories, a number of

exaggerated and extraordinary claims have been made by persons purporting to be experts on CODC. Several examples will illustrate this:

1. Gravitz and Bowden (1985, preface) say "children of alcoholics are but the visible tip of a much larger social iceberg which casts an invisible shadow over as much as 96 per cent of the population in this country."

2. Susan Cooley Ricketson, a psychotherapist who specializes in treating co-dependency, is quoted as saying: "Untreated codependency invariably leads to stress-related complications, physical illness, depression, and death" (Ricketson, 1989, p. 13, cited in Katz & Liu, 1991, p. 7).

3. In a book of readings on co-dependency published by Health Communications (1984, p. 2), Sharon Wegscheider-Cruse states: "Co-dependency is a *primary disease and a disease within every member of an alcoholic family*" (emphasis added).

4. Researchers Katz and Liu (1991) say they counted 254 separate characteristics listed by Melody Beattie in *Codependent No More* (1987), any one of which she said could indicate co-dependency.

Cermak (1986a, p. 93) found that "many therapists rush into treating co-dependent clients soon after they discover their own issues with co-dependence. This is particularly common among therapists who are adult children

of alcoholics."

Should we not question both the educational system and the credentialling process that produced the vast numbers of mental health professionals who have accepted uncritically the primarily anecdotal "evidence" on which most of the co-dependency literature is based?

Reaction to Excessive Claims

The four statements quoted above evoke skepticism from thinking laymen and require critical response from conscientious, ethical mental health professionals.

In his introduction to Dr. Marsha Vannicelli's scholarly book on group therapy for ACOAs, Dr. Peter Steinglass observed that until recently mental health professionals have stayed on the sidelines, leaving the direction of the CODC movement to lay organizers. The result was an intellectual vacuum. He said a few clinicians within the CODC movement have produced quasi-authoritative books that are almost entirely anecdotal, suggesting that the field is so new there is no systematic data, or, if scholarly work is being done, it is irrelevant (Vannicelli, 1989, p. xi).

Gomberg agrees with the need for research in her response to the notion that every member of a family in which alcoholism occurs will be adversely affected by the alcoholism. She says:

> That some family members will be disturbed is a long way from the assumption that, "most members" of the family show dysfunction. Where are the data? There are no surveys, no clinical research, no evaluations only descriptive, impressionistic statements. (Gomberg, 1989, p. 119)

Some scholarly works have been published (Brown, 1988; Vannicelli, 1989) by academic and professional publishing houses such as John Wiley & Sons and Guilford Press. But those books were not displayed on the literature tables at the CODC conferences that were so popular in the 1980s. The reason, apparently, is because the regional and national CODC conferences were sponsored by the same organizations that published much of the CODC literature written by the conference speakers, and the conferences were effective promotional tools for their book and tape sales (Kaminer, 1993).

The books that were then and still are heavily promoted by these publishers, and by the many commercial booksellers who also profit from them, are the books that *sell*, despite their dubious clinical value. The excessive claims in these books are a source of embarrassment to responsible clinicians, scholars, and authors whose work is based on theory and sound empirical research rather than mere undocumented anecdotes.

Several thought-provoking books and articles in recognized professional journals have recently pointed out errors and overstatements in some of the literature and

suggested alternate directions (Fulton & Yates, 1990; Gomberg, 1989; Haaken, 1990; Harper & Capdevila, 1990; Kaminer, 1993; Katz & Liu, 1991; Morgan, Jr., 1991; Myer, Peterson, & Stoffel-Rosales, 1991; Oliver-Diaz & O'Gorman, 1989; Peele, 1989; Peele & Brodsky, 1991; Seefeldt & Lyon, 1992; Tessina, 1991; Van-Wormer, 1989).

It is true that for years mainline clinicians shunned the CODC field altogether (Vannicelli, 1989) and even now some responsible clinicians who are attempting to conduct research in that domain feel the need to defend their work from comparison with the claims of persons who may be better-known but are less scholarly.

For example, Robert J. Ackerman, Ph.D., who is a professor of sociology at Indiana University of Pennsylvania, prefaced a workshop for mental health professionals that I attended in Chattanooga, Tennessee, on May 26, 1994, with a specific disclaimer of the "96 per cent" figure, quoted above (Gravitz & Bowden, 1985, preface). He also said that he disagrees with many of the views of John Bradshaw, whom he mentioned by name.

Other clinicians have spoken out against the excesses in the CODC field and clarified their own position with regard to the relevant issues. An example of this is the respected author, Harriet Goldhor Lerner, Ph.D., who is a staff psychologist and psychotherapist at the Menninger Clinic. She views the "opportunism of these new moral

entrepreneurs" as a major problem and argues that "although the literature legitimizes women's pursuit of greater autonomy, it identifies dependency conflicts as stemming from women's 'disease'" (Haaken, 1993, p. 323).

Lerner appears to distance herself from the CODC construct by wrapping the word "codependency" in quotation marks the one time she used it in her highly acclaimed book, *The Dance of Intimacy*:

> Kristen's story had the kind of ending we all like to hear about. Her mother eventually sought help for her "codependency." Her Dad *did* get a handle on his drinking problem, and all the family members began to conduct their relationships more functionally. (Lerner, 1989, p. 98)

Co-dependency as a "Disease"

Co-dependency is described as a "disease" (Health Communications, 1984; Mellody, 1989; Schaef, 1986; Wegscheider-Cruse, 1984) that is said to be found in the spouse, children, other relatives, and even in the friends of alcoholics. Cermak (1986a, p. 3) explains, "Co-dependence is used to describe a 'disease entity,' just as phobia, narcissistic personality disorder, and Post-Traumatic Stress Disorder (PTSD) are diagnostic entities."

However, the use of the term "disease" with regard to "symptoms," such as the 254 items Katz and Liu (1991) say were listed by Melody Beattie in the passage quoted previously, is under considerable scrutiny (Goodman, 1987;

Haaken, 1990; Harper & Capdevila, 1990; Kaminer, 1993; Katz & Liu, 1991; Peele, 1989; Peele & Brodsky, 1991; Van-Wormer, 1989).

Although she is considered to be one of the most knowledgeable authorities in the CODC field, Beattie reveals what appears to be complete lack of familiarity with the DSM diagnostic system. Footnote 7 in chapter 2 of her bestseller, *Beyond Codependency: And Getting Better All the Time*, attributes credit for originating the concept of Post Traumatic Stress Disorder (PTSD) to Cermak, whom she is quoting:

> In his writings about codependency and the adult child syndrome, Timmen Cermak calls this "Post Traumatic Stress Disorder." According to Cermak, it can happen to people who chronically live through or with events "outside the range of what is considered to be normal human experience." (Beattie, 1989, pp. 17, 20)

In a passage already quoted, CODC is said to be based on an underlying personality "disease" shared by all sufferers (Wegscheider-Cruse, 1984). However, CODC does not meet the criteria historically used by the medical and mental health professions to categorize "disease." Katz and Liu (1991) offer the following guidelines:

> *Physical ailments or sicknesses* are identified by rashes, fever, or other specific physical effects on the appearance and function of the body, and by the microbes, bacteria, or viruses that cause these effects.
>
> *Mental or emotional disorders* are identified by abnormal behaviors, thoughts, and feelings that interfere with an individual's ability to function. There are hundreds of different diagnoses listed in

> the psychiatric manuals, but the one common denominator to all serious mental disorders is that they are *outside the range of usual human experience.* (Katz & Liu, 1991, pp. 4-5)

In *Diseasing of America: Addiction Treatment Out of Control* (Peele, 1989) and *The Truth About Addiction and Recovery* (Peele & Brodsky, 1991), the authors describe the growth of the addiction treatment business as a public-relations triumph rather than a triumph of science and reason. Van-Wormer (1989) says CODC has been popularized for mass consumption and "medicalized" or made to appear legitimate, for mass treatment.

Katz and Liu (1991, p. 7) note that medical diseases, problem behaviors, and addictions are not the same thing yet they find that "self-help leaders frequently use the terms 'problem behavior,' 'addiction,' and 'progressive disease' interchangeably."

Treating newly discovered and loosely defined addictive "diseases" in hospital-like settings has become a billion dollar business (Harper & Capdevila, 1990, p. 291; Van-Wormer, 1989, p. 60).

CODC Catastrophized

Responsible clinicians are concerned that the CODC movement misleads people who are trying to manage some of the vexing but nevertheless ordinary difficulties of everyday life and relationships by attempting to persuade

them that their problems are much more serious than they really are (Katz & Liu, 1991).

At the same time, the CODC clinicians tell their clients that they are victims; they bear none of the responsibility for those problems. This catastrophizes the experiences of some people whose upbringing was perfectly normal while it gives false hope to other people with truly dysfunctional histories who require far more than "self-help palliatives" to heal their wounds (Katz & Liu, 1991, p. 17). Indeed, CODC does appear to have been catastrophized; but at the same time it is presented in self-help pop-psychology literature as an almost universal condition.

As mentioned before, Gravitz and Bowden (1985, preface) say "children of alcoholics are but the visible tip of a much larger social iceberg which casts an invisible shadow over as much as 96 per cent of the population in this country." This dubious statistic is based on their perception of the public's response to their lectures: "In towns and cities throughout the country, people have come to us saying, 'I read your book and it really helped me. But I'm not the child of an alcoholic'" (Gravitz & Bowden, 1985, preface).

Haaken observes that CODC literature says

> the person who attempts to hold the family together is the same as the alcoholic who abandons it; the person who depends upon drugs for a sense of well-being is the same as the one who depends upon people for the same feelings. There are no victims and no perpetrators in

> this no-blaming world of moral equivalents. (Haaken, 1990, p. 404)

Addiction

Peele (1989, p. 3) decries the misinterpretation of one of his earlier books, *Love and Addiction* (Peele & Brodsky, 1975), saying his entire purpose in writing it was to explain addictions as part of a larger description of people's lives. He believes that addiction is an experience that people can get caught up in but that still allows them to express their values, their skills at living, and their personal resolve--or lack of it. He does not think the label *addiction* obviates either the meaning of the addictive involvement within people's lives, or their responsibility for their misbehavior; it is their choice to continue their addiction.

For example, Peele says 40 million Americans have quit smoking. He asks what we would think of someone who did not quit smoking and chose to sue a tobacco company for addicting them, after learning that they are going to die from a smoking-related ailment (Peele, 1989)?

Peele suggests that the discrepancy between understanding addiction within the larger context of a person's entire life and regarding it as an *explanation* of that person's life underlies his opposition to the "disease theory" of addiction (Peele, 1989, p. 3).

Some authors believe Alcoholics Anonymous (AA) pushes this theory to a ridiculous extreme. Katz and Liu (1991, p. 43) cite the example of an AA leader who told his group "If you think you have a problem, or if you think you are an alcoholic, I assure you that you are. You wouldn't be thinking about it and you wouldn't be here if you weren't an alcoholic." Katz says this is like saying that if you think a freckle is cancer then it is, because according to their lopsided logic you would not be thinking you had a disease unless you actually had one.

Twelve Step Programs

Dozens of new "Twelve Step" programs, based on the AA model, use the "disease theory" as the basis for helping the loved ones of chemical, alcohol, or other addicts (see Appendix D for a list of the Twelve Steps of Alcoholics Anonymous).

These co-addicts or co-dependents meet weekly or more often in at least one and sometimes several different kinds of groups oriented toward specific problem areas of their own, which are also considered addictions, such as relationships, gambling, shopping, exercising, and sex. Yet many people find this puzzling because "habitual, voluntary behavior of this sort does not resemble what we normally think of as a disease, like cancer or diabetes" (Peele & Brodsky, 1991, p. 23). Katz agrees, saying "I do not

believe that it is accurate or useful to equate addiction with disease" (Katz & Liu, 1991, p. 6).

Referring to Twelve Step programs and the Twelve Steps of Alcoholics Anonymous on which they are based, Melody Beattie (1987, p. 177) explains, "When they become habits, the program becomes a way of life. This is called working the Steps and working the program."

Kaminer (1993, p. 6) says the self-help tradition has "always been covertly authoritarian and conformist," relying on a mystique of expertise and encouraging people "to look outside themselves for standardized instructions on how to be, teaching that different people with different problems can easily be saved by the same techniques." She says this is anathema to independent thought. Some critics consider the fostering of dependence on the support group to be one of the most disturbing effects of the CODC movement.

Tessina (1991, pp. xvi-xvii) believes that independence can come only when one makes the decision to "graduate" from the support group. She laments that the term "13th stepping" has been used as a derogatory phrase to denote inappropriate sexual intimacy of an old timer with a new member; she believes "13th stepping" should mean going beyond the 12th step and graduating from the group to healthy, autonomous living.

Fostering dependence reached its apex with the infantilization of grown men and women, reducing them to the

status of "adult children" (Katz & Liu, 1991, p. 17; Peele, 1989, p. 52). The term "adult children" is said to have been coined by author and self-described adult child Sara Hines Martin (1989, p. viii) who explained: "The term adult children comes about not because we are offspring of alcoholics but because we are children emotionally."

The helping professionals who devote their lives to treating "co-dependence" appear to be sincere in their desire to help people, and some of them achieve considerable success, up to a point. Others seem to lack the theoretical knowledge needed to conceptualize cases accurately as well as the clinical training required to treat them effectively.

Also, co-dependents can be substance abusers (Brown, 1988). Dual diagnosis cases (substance abuse combined with a mental illness) can be overlooked when symptoms of addiction are confused with symptoms of the Axis I and Axis II psychiatric disorders, which can occur concurrently and/or which addictive behavior can mimic. Many "graduates" of treatment center programs relapse repeatedly. Addiction treatment facilites not only fail to achieve lasting therapeutic success with the identified patients but also with the family members and significant others who participate in their "family" or CODC programs.

Lack of success may be because many clinicians practice at the "counseling" rather than the "psychotherapy" end of what Peterson and Nisenholz (1987, pp. 143-146)

describe as a continuum. Though some scholars and clinicians see no distinction between counseling and psychotherapy, Brammer, Shostrom, and Abrego (1989) see them as overlapping areas that many therapists switch back and forth between, as appropriate.

They describe counseling as having the following qualities: "educational, supportive, situational and developmental, problem-solving, conscious awareness, emphasis on 'normals,' focus on the present." They see psychotherapy as being "supportive (more focused), reconstructive, depth emphasis, analytic, focus on past, emphasis on 'dysfunction' or severe emotional problems" (Brammer et al., 1989, pp. 4-5).

The problems of many CODC patients are serious and cannot be dealt with effectively using elementary techniques. Cermak believes that "what many recovering clients need is a therapist trained in both the chemical dependence and the psychodynamic traditions" (Cermak, 1986a, p. 87).

CODC Is Challenged

Despite what Kaminer (1993) describes as the religious zeal of its adherents, CODC remains an unverified diagnostic entity. It was not only excluded from the latest version of the DSM, but it has been challenged by mental health professionals both inside and outside of the

addictions treatment industry (Fulton & Yates, 1990; Gomberg, 1989; Haaken, 1990, 1993; Harper & Capdevila, 1990; Hibbard, 1993; Kaminer, 1993; Katz & Liu, 1991; Oliver-Diaz & O'Gorman, 1989; Peele, 1989; Peele & Brodsky, 1991; Van-Wormer, 1989).

Using the term adult children of alcoholics (ACOA) as a broad, all-inclusive designation fails to consider the variability found in alcoholic homes and the ability of many people to develop normally in spite of an adverse childhood (Fulton & Yates, 1990; Kaminer, 1993; Katz & Liu, 1991). The co-dependence movement misleads people who are simply experiencing the ordinary--though irritating--difficulties of everyday life (Katz & Liu, 1991, p. 17).

Seefeldt and Lyon (1992, p. 588) studied research that attempted to validate 13 personality characteristics of ACOAs that were described by Janet Woititz, which they said she "apparently based on summaries of clinical impressions made during ACOA treatment." The characteristics are

> 1. ACOAs guess at what normal behavior is. 2. ACOAs have difficulty following a project through from beginning to end. 3. ACOAs lie when it would be just as easy to tell the truth. 4. ACOAs judge themselves without mercy. 5. ACOAs have difficulty having fun. 6. ACOAs take themselves very seriously. 7. ACOAs have difficulty with intimate relationships. 8. ACOAs overreact to changes over which they have no control. 9. ACOAs constantly seek approval and affirmation. 10. ACOAs usually feel they are different from other people. 11. ACOAs are super responsible or super irresponsible. 12. ACOAs are extremely loyal, even in the face of evidence that loyalty is undeserved. 13. ACOAs are impulsive. (Woititz, 1983, p. 4)

In one study of Woititz's concept number 7, Barnard and Spoentgen (1986) found that ACOAs who were not seeking treatment (persons who presumably did not feel they needed treatment) scored significantly higher on their capacity for intimate contact than either ACOAs who were seeking treatment or a control group.

Results that indicated many ACOAs were functioning well without any kind of treatment led Seefeldt and Lyon (1992) to have doubts about the validity of Woititz's description of ACOAs. For this reason they concluded that it is imperative that objective evaluations of the 13 characteristics be conducted to validate the ACOA label. They said "it is possible that we are encouraging up to 30 million individuals [the number of people thought to be co-dependent, as cited in some CODC literature] to view themselves in a way that may not only be inaccurate but may even be maladaptive" (Seefeldt & Lyon, 1992, p. 589).

This possibility is particularly interesting when compared with Woititz's curious interpretation of the results of her own doctoral dissertation research on the treatment of children of alcoholics when she was pursuing her Ed.D. degree. Here is the account as related by Stanton Peele in *Diseasing of America* (1989). "What Woititz actually discovered was that adolescents who attended Alateen (a [Twelve Step] group for [teenage] children of alcoholics) had *lower* self-esteem that [sic] those who did

not attend."

Woititz explains:

> Analysis of the data and an understanding of the alcoholic family pattern can help explain this result. Denial is a part of the disease both for the alcoholic and his family. . . . This researcher suggests that the non-Alateen group scores significantly higher than the Alateen group scores because the non-Alateen children are still in the process of denial. (Woititz, 1976, pp. 53-55, quoted in Peele, 1989, p. 88)

Peele continues:

> According to Woititz, it only *seems* that children of alcoholics have higher self-esteem when they don't enter treatment, but they are actually *denying* their low self-esteem. Woititz is confident, however, that the children will be better off when this artificial self-esteem is stripped away. (Peele, 1989, p. 88)

This kind of thinking is what people may get if they think they are co-dependent and become involved with some of the leaderless groups, or see an untrained "CODC counselor."

Many people who consider themselves co-dependent read books and attend informal groups that do not have leaders, and these people may not ever come in contact with a professionally trained, credentialed mental health professional. They do not know what other options are available to them for the resolution of their problems.

Even among the mental health professionals who participate in the CODC movement, an important distinction that I have not seen articulated is that there are significant differences between the kinds of groups available: "self-help groups" and "mutual support groups."

The terms seem to be used interchangeably in spite of the following distinctions:

> Mutual support groups generally are designed to help members deal with a specific problem or life transition, such as the death of a family member, but do not encourage lifelong membership. Most self-help groups instruct members that they must attend the group for the rest of their lives in order to maintain the recovery process.
>
> Mutual support groups frequently are supervised by individuals trained in leadership skills, who ensure that every member has an equal opportunity to share their problems and opinions and that the most vocal members do not monopolize the group or antagonize other participants. Most self-help groups are led by nonprofessionals and may prohibit professional involvement. Often the only qualifications for leadership in the self-help movement are membership in the group and familiarity with the group's program.
>
> Mutual support groups allow members to share their experiences and offer personal feedback but do not impose blanket prescriptions or behavior programs. Most self-help groups, conversely, prohibit personal advice giving but teach members that their recovery depends on their adherence to the group's program or beliefs (often the Twelve Steps used by Alcoholics Anonymous or a variation of the Steps).
>
> Mutual support groups encourage members to view their problems in the context of their lives as a whole and to believe in their capacity for complete recovery. Self-help groups teach members to view their lives in the context of their problems and to relinquish the notion that they can ever achieve complete recovery. (Katz & Liu, 1991, pp. xiii-xiv)

The presenting problem of an individual initially may appear mild, perhaps because the client gives incomplete information (Goldstein, 1990). Thus many clients who self-identify as co-dependent eventually may be found to meet the criteria for BPD. Even if that is true they are often diagnosed as having an adjustment disorder. Usually this is not accurate because the disorder has lasted longer

than the 6-month limit specified for adjustment disorders in DSM-III-R, which was in use in 1990. The rules are bent because this diagnosis allows many clients to qualify for insurance coverage (Katz & Liu, 1991, p. 20) whereas the personality disorders in Axis II are seldom covered.

What Is "Normal"?

The very first item on her list, quoted on p. 61, shows that Woititz believes that ACOAs and others who consider themselves co-dependent, which appears to include the majority of authors in the CODC field, have to guess what "normal" behavior is (Woititz, 1983, p. 4, 1985, p. 85). Thus we have clinicians who do not know "what normal is" trying to treat people who do not know "what normal is" but would like to become "normal."

Assuming that "normal" and "healthy" mean the same thing, what they are is pretty obvious to most people. A widely reported poll of over 500 authorities on family counseling (Curran, 1983) found agreement on 15 traits that are definitive of a healthy family. The healthy family

> 1. communicates and listens, 2. affirms and supports one another, 3. teaches respect for others, 4. develops a sense of trust, 5. has a sense of play and humor, 6. exhibits a sense of shared responsibility, 7. teaches a sense of right and wrong, 8. has a strong sense of family in which rituals and traditions abound, 9. has a balance of interaction among members, 10. has a shared religious core, 11. respects the privacy of one another, 12. values service to others, 13. fosters family table time and conversation, 14. shares leisure time, 15. admits to and seeks help with problems. (Curran, 1983, pp.

23-24)

The professionals who participated in this study represented five institutional areas that impact families:

> From education there were principals, counselors and teachers; from churches there were pastoral staffs, counselors and educators; from health fields there were pediatricians, school nurses, family physicians, and pediatric nurse practitioners; from family counseling there were counselors, therapists, mental health personnel and social workers; and from voluntary organizations there were directors, leaders and coaches. (Curran, 1983, p. 19)

According to Katz and Liu (1991, pp. 16-17)

> Most of the feelings and behaviors listed as co-dependence traits are perfectly normal. They do not indicate that we came from dysfunctional families or are in one now. They do not prove that we are addicts or that we have a dread disease. All they prove is that the authors of these lists have contrived a theory so broad, so multifaceted that it is virtually meaningless.

Many mental health professionals have difficulty comprehending how the whole idea of co-dependency came to be considered so important. Darwin Dorr said:

> My wife, my wife's boss, and I, all three, joke that we're going to write an article someday and call it *Co-dependency: They used to call it love.* You know, my wife's boss said, "My wife and I *like* to be together, we *like* to do things, we *like* to check in during the day. Does that mean I'm co-dependent? I used to think it was love. The term [co-dependent] is so overused. (Personal communication, June 5, 1992)

The Controversy

Noting that recent articles have asked if America is becoming addicted to addictions, Gomberg (1989, p. 127) says this is a commentary on the lonely crowd. In my own

practice I have observed that many people who consider themselves co-dependent describe spending what seems to me an inordinate amount of time attending Twelve Step meetings, plus talking in person or on the telephone to their "sponsor."

At an ACOA conference in Chicago, clinicians Patty O'Gorman and Philip Oliver-Diaz said that recovering co-dependent people spend as much time in their recovery groups and promoting their new beliefs as they used to spend in whatever it is they are recovering from! They lamented that even if they are physically present in their houses these people are so deeply engrossed in their telephone conversations with their sponsor or other "people with no last names" that they are not paying attention to their children. Yet when confronted about this they do not consider it to be neglect of their families (Oliver-Diaz & O'Gorman, 1989).

A major problem with support groups is that a great deal of influence can be exerted by lay leaders whose qualifications are merely the fact that they have "survived" certain life experiences (Harper & Capdevila, 1990; Kaminer, 1993; Katz & Liu, 1991) that they are eager to share. Some clinicians believe that the idea of the "sponsor" is one of the most dubious practices of AA-like groups: Katz and Liu (1991, p. 55) observe that the sponsor is called upon to serve as "friend, role model, and counselor but may be

qualified for none of these." Tessina (1991, p. 60) says a sponsor may mean well but unintentionally make matters worse.

Constructive friendships are based on mutual strengths, not on weaknesses or addictions and the mere fact of being "in recovery." According to Katz and Liu (1991, p. 56) "relationships that are based on mutual weakness cannot serve as sources of strength or enrichment."

Neither A.A. nor even hospital programs for alcoholism actually treat *biological* causes; "the same group discussions and exhortations that have been used for the last fifty years are employed in hospital programs" (Peele & Brodsky, 1991, p. 23).

Peele and Brodsky (1991, p. 29) quote George Vaillant's classic book, *The Natural History of Alcoholism: Causes, Patterns, and Paths to Recovery* (1983), in stating that "the *number* of self-curers is triple or more the number of successful treatment or A.A. cases." That means *you are three times more likely to succeed in quitting drinking (or whatever) by yourself than you would in a hospital, in a specialized alcohol treatment center, or an A.A. type group.* People who seriously work at stopping drinking on their own are more likely to succeed than those who attend A.A.

Peele and Brodsky (1991, p. 11) quote a 1990 study in *American Health* magazine in which a Gallup Poll found

that Americans are about 10 times as likely to make the changes they wish to make in their lives (for example, to become sober) on their own as they are with doctors, therapists, or self-help groups. Katz cites clinical examples from his practice to illustrate his belief that

> individuals and families are enormously resilient and that many more can develop the resilience to completely recover from even the most tragic or profound crises. Yet such resilience is undermined by self-help programs that teach members to view themselves as powerless and disease-ridden, by "recovery experts" who maintain that virtually our entire society requires lifetime treatment. (Katz & Liu, 1991, p. xiii)

Common sense tells us that recovery from anything depends on the client's level of motivation. Irvin Yalom says: "Every therapist knows that the crucial first step in therapy is the patient's assumption of responsibility for his or her life predicament" (Yalom, 1989, p. 8). Surely recovery from co-dependence is no different.

CHAPTER 3

REVIEW OF BORDERLINE PERSONALITY DISORDER LITERATURE

Introduction

One unfortunate similarity between CODC and BPD is the amount of disagreement regarding definition and criteria among the experts in each field. There are almost as many perspectives on BPD as there are people working in this field. These include disputes between academic researchers and practicing clinicians on matters as basic as etiology, definition, and diagnosis. Frances, Clarkin, Gilmore, Hurt, and Brown (1984) refer to the "beguiling vagueness" of BPD, saying the concept has been used in so many ways it defies description.

In addressing the challenge of understanding the various alternative perspectives on the classification of personality disorders, Lee Anna Clark (1995, p. 483) finds that the terminology used is "often ambiguous, confusing, or inconsistent" and notes that similar issues are discussed using different terminology or the same terms are applied in different ways. Widiger, Miele, and Tilly (1992) note that

one of the problems in diagnosing BPD has been the way definitions change over time, for example, the pace at which the DSM is being revised.

Gunderson and Zanarini (1987) point out that the kind of research that would examine the integrity of the personality disorder categories is still being done. One solution that has been proposed is to have two diagnostic systems, one for research and one for clinical practice. But which ones? Dimensional? Categorical? Prototypical? Ideal types? Although the quality of the debate is on a higher intellectual plane, the different ways of describing BPD are just as confusing as the different descriptions we saw in the CODC literature.

Two Borderline Types

The Inpatient Stereotype

Because of their larger numbers, concentration in hospitals and community mental health centers, and hence their availability for research, the advances in our understanding of BPD have resulted predominantly from the study of inpatient populations (Linehan, 1993a, 1993b). The inpatient group tends to be low-functioning and is the source of the borderline stereotype of a difficult, disruptive individual who creates havoc among other patients, splits staff, and is a general pain in the neck. You could almost base the diagnosis on the level of the

clinician's blood pressure! Because of their visibility and sheer numbers it is this inpatient group, rather than the more dispersed, intelligent, and higher functioning outpatient population, that is most frequently described in the literature (Aronson, 1989; Sweeney, 1987).

High-Functioning Outpatients

Michael Stone (1990, p. 189) describes many BPD patients with IQs one standard deviation above the mean (IQ of about 115) including "two physicians, three social workers, a psychologist, a teacher, a laboratory manager, a financier, and an artist."

In his outcome studies, however, Stone found that only at two standard deviations above the mean (IQ of about 130) did they appear to have a real advantage; in this group almost all of the individuals became professionals. They included: "two social workers, a psychologist, a lawyer, a systems analyst, a physician, a nurse, an accountant, and an engineer" (Stone, 1990, p. 189).

Patients in the high-functioning group generally are able to perform well professionally but their personal relationships may be chaotic (personal communication, Darwin Dorr, June 5, 1992). The high-functioning group includes attorneys, doctors, dentists, psychotherapists, housewives, social workers, industrialists, and scholars (Goldstein, 1990; Stone, 1990). We do not hear very much about these

types of individuals being included in the BPD category. It may be that because of their professional status and social position they choose to maintain a low profile. With this group, the diagnostic problem is to "differentiate borderline pathology from neurotic or higher-level character pathology" (Meissner, 1988, p. 3).

Origin of the Term "Borderline"

Reed David Goldstein observed that A. Stern (1938) was the first person to use the term "borderline" in a formalized manner. Stern felt that these patients evidenced 10 major characteristics: narcissism, psychic bleeding, inordinate hypersensitivity, psychic rigidity, negative therapeutic reactions, deeply imbedded feelings of inferiority, masochism, somatic anxiety or insecurity, the use of projective mechanisms, and the tendency to experience difficulty in reality testing, especially in interpersonal settings (Goldstein, 1991, p. 6).

Though Stern considered them too ill for psychoanalysis, he felt that these patients had relatively stable psychopathology; they were not psychotic. In that respect he agrees with one of the major current theorists, Otto Kernberg, who "based his definition of the borderline patient in part on the relative stability of borderline personality psychopathology" (Goldstein, 1991, p. 6).

Diagnosing Borderline Personality Disorder

Kernberg suggested that borderline patients' core difficulty lies in their inability to bring together and integrate loving and hating aspects of both their self-image and their image of another person. Kernberg's observation was that these patients cannot sustain a sense that they care for the person who frustrates them. Kernberg saw this characteristic failure in the achievement and tolerance of ambivalence and in the modification of affects as diagnostic of the borderline individual (Shapiro, 1978, p. 1307). Gunderson and Singer (1975, p. 3) said that *anger* and its defenses, such as *splitting,* are a "major discriminating feature" to identify four subgroups of BPD patients. Goldstein (1990, p. 46) noted that *fear of abandonment* is a "core problem" for most borderline individuals, and Masterson (1988, p. 119) described the *distancing* defense as "crucial" for a borderline's success at work or school. Goldstein (1990, p. 50) also said that virtually all of the other characteristics described as problematic for borderline persons are the result of their *intense and unstable personal relationships.*

The Classification Controversy

The classification of BPD population(s) is the subject of vigorous and ongoing controversy. As previously mentioned, there are vast and significant differences of

opinion, especially between researchers and clinicians, on the nature, definition, and diagnosis of BPD.

Otto F. Kernberg describes a problem with using the DSM-III-R criteria to arrive at a clinical diagnosis. He says that although it is well suited for research purposes, "this approach to diagnosis--which was derived largely from the work of John G. Gunderson and Jonathan E. Kolb (1978), Christopher J. Perry and Gerald L. Klerman (1980), and Theodore Millon (1981)--has proved less than ideal for clinical purposes." He says this is because "it fails to distinguish the common features of severe personality disorders from those of the less severe ones" (Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989, p. 5).

Borderline Personality Organization

Kernberg favors the less precise but etiologically more relevant concept of borderline personality organization, which is structural as well as descriptive. It is based on three structural criteria; the following discussion is condensed from Kernberg et al. (1989, pp. 5-7).

Identity Diffusion

Identity diffusion is the lack of integration of the concept of the self or of significant others and is evidenced in the patient's experience of chronic emptiness, contradictory self-perceptions and behavior, and

impoverished and contradictory perceptions of other people, and the difficulty the patient has in communicating his/her significant interactions with others to the therapist. This leads to difficulty of the therapist in empathizing with the individual.

Level of Defensive Operations

Unlike neurotic patients who utilize high-level defensive operations, these patients use the primitive defenses of splitting, which include primitive idealization, projective identification, denial, omnipotent control, and devaluation.

Capacity for Reality Testing

Reality testing is the capacity to differentiate one's self from nonself and to differentiate intrapsychic vs. external origins of perceptions and stimuli, and the ability to evaluate one's own affect, behavior, and thought content according to accepted social norms. Kernberg says this capacity is retained "despite distortions caused by defenses such as extreme forms of projection and problems in the sense of reality" (Goldstein, 1990, p. 19).

According to James Masterson, the real self emerges from the dual symbiotic mother-child unit and develops through the stages of separation/individuation to become separate, whole, and autonomous and to take on its own capacities listed below:

> Spontaneity and alertness and aliveness of affect; Self-entitlement, self-activation, assertion, support; Acknowledgment of self-activation and maintenance of self-esteem; Soothing of painful affects; Continuity of self; Commitment; Creativity. (Masterson, 1985, pp. 171-172)

From the perspective of this theoretical position, Masterson and Klein (1989, p. 6) recommended that the 11 personality disorders be reduced to 4, with subdivisions: (1) Borderline Personality Disorder would consist of Histrionic, Avoidant, Dependent, Passive-aggressive, and Compulsive; (2) Narcissistic Personality Disorder would consist of Exhibitionistic and Closet; (3) Antisocial Personality Disorder would stand alone, and category (4) Paranoid and Schizoid Personality Disorders would consist of Paranoid, Schizoid, and Schizotypal.

A principal difference among these categories is the way in which the self relates to the object. In the borderline personality the self clings to or distances from the object. In the narcissistic disorder the self co-opts the object; in the psychopathic, antisocial disorders the self is totally emotionally detached or uninvolved with the object. In the schizoid disorders the self relates to the object by distancing, and in the paranoid there is major use of projection. Crucial diagnostic and treatment implications arise from the determination as to whether the self clings to the object, co-opts the object, detaches from the object, or distances from and projects on the object

(Masterson & Klein, 1989, p. 7).

According to Stratton and Hayes (1988, pp. 124-125), the term object refers to "the people, parts of people or things to whom the individual relates." The details of various classification systems are not important to this study and are not dwelt on beyond providing an awareness that they exist.

What is important here is to use as many as possible of the characteristics or criteria that are considered relevant in the various diagnostic systems as I attempt to compare BPD with CODC.

Diagnostic Systems

I base much of this discussion on the DSM-III-R criteria for BPD (which are the same as DSM-III) since the classic co-dependence books were written during the 1980s while they were the diagnostic standard.

Both the DSM-III-R and new DSM-IV criteria for BPD are appended. (See Appendix B and Appendix C.)

Discussion

Thomas A. Widiger, Ph.D., took a 2-year leave-of-absence from his job as Professor of Psychology at the University of Kentucky to work full time on the DSM-IV. "His primary responsibility during this time was to help develop and monitor the process by which DSM-IV would be constructed." "He is the principle editor of the 5-volume

DSM-IV Sourcebook that will provide the rationale and empirical support for all of the major decisions that were made for DSM-IV" (American Psychological Association [APA], 1994, p. 5).

In addition, despite all the care that was taken with the new edition, there are what appear to be contradictory statements within DSM-IV. For example, as with all of the other disorders, the personality disorder criteria in DSM-IV are listed in descending order of importance. The first criterion given for BPD is "frantic efforts to avoid real or imagined abandonment." Yet in the discussion of diagnostic features (American Psychiatric Association, 1994, p. 650) the very first sentence says: "The essential feature of Borderline Personality Disorder is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts." This appears to be a contradiction because a few pages later, on p. 654 under diagnostic criteria, we find a different order: "instability of interpersonal relationships" is listed as criterion #2, "unstable self-image" is criterion #3, "affective instability" is criterion #6, and "impulsivity in at least two areas" is criterion #4.

Gunderson and Zanarini (1987) noted that controversy persisted around failure of DSM-III to include brief

dystonic, psychotic-like experiences and the use of categorical versus dimensional models. Dahl (1995, p. 161) says the controversy is over whether psychotic symptoms "are an inherent part" of the BPD concept or whether they constitute an associated feature. He said his own experience with hospitalized patients has shown that only 24% of BPD patients experienced psychotic episodes whereas 67% of patients with schizotypal personality disorder experienced them. Dahl (1995, p. 161) suggests the following as an alternative definition of criterion 9 for DSM-IV: "Reality testing instability: transient, stress-related impairment of reality testing shown as brief episodes of psychotic symptoms (hallucinations, delusions, thought disorder, or confusion)." In his discussion of how to recognize personality disorders during the first interview with a patient, Morrison (1995, p. 214) does not list psychotic symptoms among his defining criteria for BPD.

Trull, Widiger, and Guthrie (1990) state that though the DSM-III-R provides categorical diagnoses, there are many in the field who argue that a dimensional model is preferable. Taylor (1995, p. 170) notes the existence of "considerable evidence that personality disorders are dimensional and do not fall into the categories specified in DSM-III-R."

R. D. Goldstein (1991, p. 81) cites references that indicate a dimensional model decreases the likelihood of

incorrectly assigning a patient to one neat, discrete category when there is evidence of characteristics that also fall outside that category. It allows for more flexibility (Trull et al., 1990; Widiger, 1992) whereas a categorical system tends to lose information and attempts to fit people, sometimes incorrectly, into rigid categories. Taylor (1995, p. 170) refers to several studies that suggest that BPD is not a discrete category and that it might be more accurately defined as severe neuroticism with minor contributions from other personality dimensions.

Taylor (1995, p. 170) cites the fact that BPD occurs as the only diagnosis of an individual in only 3-10% of cases as evidence that the cases having only a single personality disorder may represent failures to detect other personality disorders that may actually be present. Tyrer (1995, p. 30) also observes that BPD is rarely found alone and that it is difficult to distinguish it from histrionic, antisocial, and narcissistic personality disorders that are also found in the "flamboyant cluster."

Aronson (1989) says that many of the borderline cases cited in the classic psychoanalytic literature would not meet the modern DSM-III criteria for BPD because it deals with a more symptomatic subgroup of psychostructural borderline subjects.

In a review of the relevant empirical, conceptual, and clinical literature, Gunderson and Sabo (1993) explore

the phenomenological and conceptual interface between BPD and Post-Traumatic Stress Disorder (PTSD). They state that the clinical diagnosis of BPD is appropriate for describing a personality whose very warp and woof are traceable to the complex intermingling of emotional neglect and misunderstanding that began in the patient's childhood.

The abstract of a doctoral dissertation by Pagano (1992) reported that childhood trauma was the best predictor of the borderline patient's regressive behavior in psychiatric treatment, of the anger and hostility they experience in relationships, and of their overdependence on their partners in relationships; it was also the best predictor of overall severity of borderline psychopathology. Morrison (1995, p. 96) links a history of childhood sexual molestation with the diagnosis of BPD in adult patients.

In an early major review of BPD, Gunderson and Singer (1975, p. 2) observed that there seems to be a remarkable contrast between borderline outpatients who seek treatment voluntarily and borderline inpatients who are often referred for treatment by others. These patients range from wealthy, high-functioning professionals who can afford long-term psychoanalytic therapy to low-functioning folks who show up in crisis at psychiatric hospitals.

These findings were confirmed in a study of why BPD patients drop out of therapy. Gunderson, Frank, Ronningstam, Wachter, et al. (1989) studied 60 patients

admitted to a psychiatric hospital between January 1985 and June 1986, screened by five inclusion criteria. Thirty-six (60%) of the patients discontinued within the first 6 months, 6 in the first week. They compared these figures with the 23% dropout rate reported in an earlier survey of BPD outpatients. The difference was attributed to the higher level of education and the higher socioeconomic status of the outpatients.

Another possible factor in dropout vs. successful completion of treatment may be the different approach of male and female therapists and the fact that most BPD patients are women who have difficulty with relationships. Sansone, Fine, and Dennis (1991, p. 177) found that while not statistically significant due to sample size, "5 out of 6 (83%) female respondents noted that they had successfully treated borderlines, while only 16 of 33 (48%) males did so."

Schwartz, Wiggins, and Norko (1989, p. 1) found that "commitment to a more scientific psychiatry has led some researchers to seek greater accuracy in diagnoses based on 'prototypes.'" Prototypes can be defined through "listing the features of a category. Individuals need not possess *all* of these features in order to fall into the category. That is to say, the features listed are not 'necessary conditions' for class membership" (Schwartz et al., 1989, p. 2).

Most of the features of what is generally accepted as the prototype of the BPD patient are included in the DSM-III criteria. In contrast to the criteria for other personality disorders, these reflect the prototype view of classification: "The descriptors are those frequently found in borderline patients rather than defining characteristics that are invariably present. The only feature not listed in the DSM-III is 'intense transference,' whose theoretical implications make it unsuitable" (Hilbrand & Hirt, 1987, p. 303).

Aaron Beck and his associates point out that the distinction between various usages of the term "borderline" is neither trivial nor academic. It is particularly important to pay attention to the way psychodynamically oriented authors define the term borderline. Many patients they label borderline would meet the criteria for other personality disorders. Indeed, in one study "only 40% of a sample of patients who had been classified as 'borderline' using personality structure criteria met DSM-III criteria for BPD" (Beck, Freeman, & Associates, 1990, p. 178).

Morey and Ochoa (1989, p. 181) found that in actual practice, the clinical diagnosis of personality disorders often diverge from the criteria of DSM-III. They believe

> *the success of the DSM-III strategy for improvement of clinical diagnosis is predicated upon the assumption that clinicians will adhere relatively carefully to the specified criteria in assigning diagnoses.* If clinicians fail to follow the DSM-III diagnostic

criteria, then the subsequent diagnoses are not accurate reflections of DSM-III constructs.

The effort to achieve uniformity in characterizing borderline patients culminated in the approach represented by the concept of BPD. But the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)* definition is narrow and eliminates the possibility of this diagnosis for many individuals who would typically be diagnosed as borderline.

When one is using the diagnostic criteria of the DSM-III-R, persons with fewer than five symptoms, for example those with four or three or less, still display borderline pathology (Nurnberg, Hurt, Feldman, & Suh, 1988; Widiger et al., 1992). Furthermore, the calculations of Widiger et al. (1992) indicate that there are 162 combinations of borderline features possible in persons who do not meet the DSM-III-R criteria. They say that patients with four symptoms are more similar to patients with five symptoms than they are to patients with none.

Hurt et al. (1990, p. 124) were interested in "whether any 5 of the 8 criteria are equally optimal," and "whether any particular combination(s) of criteria are more useful than others." Unstable interpersonal relationships and affective instability were the best combination, achieving a 60% reduction in diagnostic error.

Hurt et al. (1990) did a complex clustering type of analysis of 465 cases, predominantly young adult, unmarried,

White females with at least high-school education, who were employed in semiprofessional or clerical trades. They came up with three clusters of borderline patients depending on whether they met certain diagnostic criteria.

The following are their three clusters with the DSM-III-R criteria that are included in each:

Criteria 1, 3, 4 = affective cluster: Includes the following diagnostic criteria, "(1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of over idealization and devaluation"; "(3) affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days"; and "(4) inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger, recurrent physical fights" (American Psychiatric Association, 1987, p. 347).

Criteria 2, 5 = impulsivity cluster: includes the following diagnostic criteria, "(2) impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance use, shoplifting, reckless driving, binge eating (Do not include suicidal or self-mutilating behavior covered in [5])," and "(5) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior" (American Psychiatric Association, 1987, p. 347).

Criteria 6, 7, 8 = identity cluster: includes the following diagnostic criteria, "(6) marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values"; "(7) chronic feelings of emptiness or boredom"; and "(8) frantic efforts to avoid real or imagined abandonment" (American Psychiatric Association, 1987, p. 347).

Commenting on the above study by Hurt et al. (1990, p. 124), Stone (1990, p. 10) felt there was reason to regard the items of the affective and impulsivity subtypes "as the most *typical* features of BPD and those that most successfully discriminate it from its conceptual neighbors," such as schizotypal and narcissistic personality disorders. On the other hand, Dorr (personal communication, June 5, 1992) commented that people he has known who have called themselves co-dependent fit into the identity cluster; they define themselves in terms of their relationships as opposed to themselves.

As mentioned previously, Kernberg points out significant problems with using the DSM-III-R criteria to arrive at a clinical diagnosis of BPD "because it fails to distinguish the common features of severe personality disorders from those of the less severe ones" (Kernberg et al., 1989, p. 5). As long ago as 1874, Hughlings Jackson advocated a dualistic classification system, one for

research and one for clinical use. The "same idea has been proposed by Zubin (1984) and others (Berner & Katschnig, 1984) for DSM-IV" (Schwartz et al., 1989, p. 8).

Fifteen of the 21 advisors studying proposed changes for DSM-IV favored the addition of a cognitive-perceptual criterion to help distinguish BPD from the psychotic experiences found in other diagnostic groups; some felt that this feature is central to the borderline construct (Gunderson, Zanarini, & Kisiel, 1991, p. 347).

Hilbrand and Hirt (1987, p. 305), utilizing a prototype developed by Clarkin et al. (1983), which was based upon the empirical prevalence of diagnostic features, found that "impulsivity, unstable/intense relationships, intense/uncontrollable anger, and affective instability occurred in 90% of their borderline cases." Studies have shown that "emptiness is highly discriminating for the BPD diagnosis ($p < .001$) whereas boredom is not" (Gunderson et al., 1991, p. 346).

Other studies indicate that "disturbed interpersonal relations and impulsivity were the most discriminating criteria" in determining BPD. They found that it is possible to make an accurate diagnosis of BPD using 3 out of 6 of a revised set of possible criteria instead of the present 5 out of 8 (Nurnberg, Hurt, Feldman, & Suh, 1987, p. 314; Nurnberg et al., 1991, p. 222). This would reduce the possible combinations from 93 to 42 and reduce the confusion

resulting from heterogeneity.

A Possible Solution

Schwartz et al. (1989, p. 3) note that in the 1960s Karl Jaspers proposed the notion of "ideal types," such as sociologist Max Weber's "the protestant ethic" and "the spirit of capitalism," as an alternative to multiple diagnostic systems. Jaspers "perceived in Weber's methods a way of categorizing those psychiatric disorders that eluded conceptualization as syndromes or disease entities" (Schwartz et al., 1989, p. 3). For Jaspers, they said, ideal types "unify and relate the attributes of the disorder. An ideal type defines a unified whole of which the various attributes are the parts" (Schwartz et al., 1989, p. 5).

Schwartz et al. (1989, p. 8) suggest that "ideal types . . . could provide a single classification scheme that would serve the purposes of both clinicians and researchers."

CHAPTER 4

REVIEW OF CODC AND BPD SIMILARITIES

In this chapter I begin by discussing CODC and BPD in separate sections. In a third section I mention briefly the decision not to include CODC in DSM-IV and refer to works by a psychiatrist, Timmen Cermak, a writer, John Bradshaw, and the author of a doctoral dissertation, Laurie Hoover, all of whom compare CODC with BPD.

CODC

As the CODC concept began to receive publicity, thousands of relatives of alcoholics and other addicted persons saw themselves in the numerous "symptoms" claimed to be "diagnostic" of CODC. These "symptoms" include ambivalence, anger, rigidity in attitudes and behavior, shame and low self-esteem, impulsivity, the need to control others, avoidance of conflict, difficulty identifying and expressing one's own feelings, need for the approval of others, perfectionism, preoccupation with relationships, and a high tolerance for inappropriate behavior (Beattie, 1987; Black, 1981; Bradshaw, 1988; Cermak, 1986a; Gravitz &

Bowden, 1985; Health Communications, 1984; Larsen, 1985; Mellody, 1989; Schaef, 1986; Subby, 1987; Wegscheider-Cruse, 1987; Woititz, 1985).

Almost a cult, with leaders whose names were household words, CODC workshops attracted thousands of people during the height of their popularity from the mid to late 1980s. Goodman (1987, p. 162) observed that although there can be little argument that some (perhaps many) people who grew up in alcoholic families are negatively affected by the experience, he believes "it is unwise to assume that: (a) all people are affected in the same way, (b) their experiences were necessarily negative, or (c) these people, as adults, are psychologically maladjusted and therefore in need of counseling or a recovery program."

The public may have reached that same conclusion because the pace seems to be slowing down. Kaminer (1993, p. 88) found that the number of co-dependence conferences and conference attendance has declined since 1990. Also, the demand for periodicals devoted to CODC has declined. Publications such as *Changes: For and About Adult Children* and *Focus* have folded and/or been incorporated into one of the quasi-professional publications such as *Professional Counselor: The Voice of the Treatment Field.*

Several authors have pointed out that it has become increasingly clear that CODC literature and the numerous

recovery groups that draw on this literature pathologize caretaker dilemmas, especially the role of women, and vastly oversimplify problems of human dependency and interdependency (Haaken, 1990; Seefeldt & Lyon, 1992). Indeed, Hogg and Frank (1992, p. 374) quote Loulan (1990) as calling "the co-dependency field a 'woman hating big business.'"

Although the market for large regional and national CODC conferences may have peaked, the market for books on CODC targeted for women appears strong. In addition, there seems to be an emerging market for "co-dependencylike" books for men. Co-dependency still commands a large part of the market in self-help literature. Major bookstore chains have entire sections devoted to topics such as "recovery" and "co-dependency" (Seefeldt & Lyon, 1992).

Figures published in 1989 show that the combined sales of just six books from only one of the publishers in this field totaled 3,250,000 copies (Health Communications, 1989.) The six books consisted of the following: *Adult Children of Alcoholics*, 1,100,000; *Healing the Child Within*, 500,000; *Bradshaw On: The Family*, 350,000; *Healing the Shame That Binds You*, 300,000; *Struggle for Intimacy*, 600,000; and *Daily Affirmations for Adult Children of Alcoholics*, 400,000. Kaminer (1993, p. 11) found that the publisher's 1991 figures showed that in the ensuing 2 years

those figures had skyrocketed with the combined sales of only four of those books totaling 3,600,000: *Adult Children of Alcoholics*, 2,000,000; *Healing the Child Within*, 800,000; *Bradshaw On: The Family*, 800,000; and *Healing the Shame That Binds You*, 800,000.

Kaminer (1993, p. 11) also quotes the 1991 figures from Harper & Row: *Codependent No More*, 2,000,000; *Beyond Codependency*, 500,000; *Co-Dependence: Misunderstood--Mistreated*, 300,000; *Women's Reality. . .*, 300,000; and *Meditations for Women Who Do Too Much*, 400,000.

Kaminer says that what she finds striking about the 35 or so co-dependency books she has read is their "earnest fatuity" and their sameness; she finds it sobering that millions of people take them seriously (Kaminer, 1993, pp. 7, 12). She believes that "we should worry about the willingness of so many to believe that the answers to existential questions can be encapsulated in the portentous pronouncements of bumper-sticker books," adding that "only people who die very young learn all they really need to know in kindergarten" (Kaminer, 1993, p. 7).

Clinical psychologist Stan J. Katz and co-author Aimee Liu (1991) counted 254 separate characteristics listed by popular author Melody Beattie (1987) between pp. 37 and 45 of her bestseller *Codependent No More*, any one of which she said could indicate co-dependency. Sarcastically they

observe:

> This list, which she warns is "not all-inclusive," includes such critical indicators as "wish good things would happen to them," "think and talk a lot about other people," "get frustrated and angry," "get confused," "advise," "gauge their words carefully to achieve a desired effect." Beattie also includes contradictory characteristics such as "say everything is their fault," and "say nothing is their fault," "take themselves seriously," and "don't take themselves seriously." (Katz & Liu, 1991, p. 16)

According to the blurb on the cover of *Codependent No More* (1987), Beattie's qualifications as an authority on co-dependence are the fact that she is "a recovering alcoholic and former chemical dependency counselor." There is no mention of academic training. Katz and Liu (1991) point out that the "criteria" she lists are so general we all fit at least one of them so it would appear that we all must be co-dependent, an impression that appears to have been very good for book sales and lecture attendance.

At least some of the speakers were doing very well financially. As of February 1990 Katz and Liu (1991, p. 16) said author/lecturer John Bradshaw was getting upwards of $6,500 per day for speaking engagements, plus all expenses and first-class air fare. Kaminer (1993, p. 100) noted that some categories of mental health professionals can get continuing education credits (CEUs) for attending conferences on CODC, which she says is "a little like getting CEUs for watching 'Oprah,'" adding, "if this is how therapists are being trained, clients are in more trouble

than they know."

As Katz and Liu point out, most of the feelings and behaviors on Beattie's list are perfectly normal and do not prove that a person who exhibits them came from a dysfunctional family, is in such a family now, is an addict, or has a "dread disease" (Katz & Liu, 1991, p. 16). All it proves, they say, is that the author of the list has presented a theory that is so broad it is virtually meaningless.

Trade Publications

As noted earlier, most of the published materials on CODC are written in a popular rather than a scholarly format and do not have an index, making it difficult to conduct research on their claims.

At least 25 of the popular books on co-dependency, ACOAs, and related topics that were consulted during this research lacked indices (Ackerman, 1989, 1993; Beattie, 1987, 1989, 1990; Black, 1981, 1985; Booth, 1991; Bradshaw, 1988; Covington & Beckett, 1988; Dean, 1988; Health Communications, 1984; Larsen, 1985, 1987; Satir, 1976, 1978; Schaef, 1986, 1987; Schaeffer, 1987; Subby, 1987; Tessina, 1991; Wegscheider-Cruse, 1987; Weiss & Weiss, 1989; Woititz, 1985, 1987). It is frustrating and time-consuming to locate material in them.

Kaminer (1993, pp. 16-17) notes that confession of

personal experience with addiction is predictable in these publications and appears to be viewed as an important credential. Van-Wormer (1989) refers to a particular CODC book as having been written from a "para-professional" rather than a professional perspective, which does seem to be the rule rather than the exception in this body of literature. Those authors who do have professional credentials are careful to cite them. However, most of the time it appears that Kaminer was accurate in saying that "experts who decline to cloak themselves in professional expertise, because they have none, invoke the moral authority we grant victims by confessing their addictions" (Kaminer, 1993, p. 17).

Until the late 1980s there had been very few articles on CODC in psychological, psychiatric, or other refereed professional journals. Most of the "journal articles" on CODC were in publications such as: *Alcoholism Treatment Quarterly, Drugs and Society, International Journal of the Addictions, Journal of Chemical Dependency Treatment, Journal of Psychoactive Drugs, Journal of Studies on Alcohol, Journal of Substance Abuse Treatment, Quarterly Journal of Studies on Alcohol,* and *The U.S. Journal of Drug and Alcohol Dependence*. Few, if any, of these publications are available in academic libraries so their articles must be obtained through interlibrary loans.

BPD

Psychiatrist James Masterson is one of the leading authorities on the treatment of BPD. He takes the broad, inclusive approach that there is a very wide spectrum within each of the personality disorder diagnostic categories. He finds that they range from lower-level, poorly functioning patients to higher-level, better functioning patients (Masterson & Klein, 1989).

Although the stereotypical borderline is a low-functioning individual who creates havoc in any setting in which he or she is found, research by Stone (1990, p. 189) describes many BPD patients with IQs one standard deviation above the mean (IQ of about 115,) including "two physicians, three social workers, a psychologist, a teacher, a laboratory manager, a financier, and an artist."

However, Stone found that only at two standard deviations above the mean (IQ of about 130) did they appear to have a real advantage; in this group almost all of the individuals became professionals. They included: "two social workers, a psychologist, a lawyer, a systems analyst, a physician, a nurse, an accountant, and an engineer" (Stone, 1990, p. 189).

Because of the stigma attached to the BPD label, I have noticed that very few mental health professionals would think of applying the term "borderline" to any of their own characteristics. Yet, perhaps because it is more innocuous,

mental health professionals readily admit to having some "co-dependent" characteristics, even though they may be describing the same characteristics in both cases! This is especially true of professionals whose experience has been with the stereotypical borderline inpatients. To mental health professionals who have worked primarily in inpatient settings, the idea of a "high-functioning" borderline is a contradiction in terms.

CODC vs. BPD

A question about the legitimacy of co-dependency as a diagnosis was phoned in on June 4, 1994, during a live satellite videoconference on "Highlights of the DSM-IV," sponsored by the American Psychological Association and National Council of Schools and Programs of Professional Psychology (APA and NCSPPP) (1994). The panel featured Thomas A. Widiger, Ph.D., Lee Anna Clark, Ph.D., and Peter E. Nathan, Ph.D., who had played major roles in the DSM revision.

Dr. Widiger responded to the question, explaining that there had been "insufficient empirical data" to justify adding categories for co-dependency or adult children of alcoholics (ACOA) to DSM-IV (American Psychiatric Association, 1994). The implied reason for not creating new categories was that there already exist categories into which these classes of people can be placed.

As noted above, Dr. Timmen Cermak has documented many similarities between CODC and BPD. He observes that "the clinical distinction between overt Borderline Personality Disorder and active co-dependence is often hazy and may take more than one interview to evaluate" (Cermak, 1986a, p. 19, 1986b). He says the reason for this is because

> at worst, chemically dependent families are breeding grounds for the development of Borderline Personalities. At best, they continue to give rise to succeeding generations of chemical dependents and co-dependents. Not surprisingly, they also give rise to a lot of CD therapists and other helping professionals. (Cermak, 1986a, p. 59)

However, as we have already noted, Cermak sees enough distinction to propose a separate category for co-dependence within the personality disorders (Cermak, 1986b), seeing co-dependence as a complement of narcissism and integrating it into the diagnostic system of the DSM (Cermak, 1991).

Cermak (1986a, p. 86) says co-dependents, in what he describes as stages I and II of the recovery process, can be indistinguishable from borderline clients. He suggests that the true depth of the distress of co-dependent persons may not be detected because of the fact that

> many co-dependent groups begin with a meditative exercise designed to diminish anxiety, followed by a formal check-in by group members. Clients in stages I and II may require such imposed structure in order to tolerate being in groups. But some may reach the point at which they are ready to start facing the difficulty they have in letting others know their need

> for attention. As long as the meditation quiets their anxiety and the check-in satisfies their need for attention, they are never required to experience their usual patterns (e.g. distancing themselves from their personal needs in order to diminish their anxiety). (Cermak, 1986a, pp. 85-86)

John Bradshaw is another individual who has become popular as a speaker and writer on CODC and is perceived to be an authority on the subject. When addressing a group of professionals in the CODC field, Bradshaw once observed that being called "co-dependent" seems a lot better than being called a "borderline" (Bradshaw, 1989). My interpretation of the audience's laughter in response to that observation is that they understood the comment to relate to the stigma associated with the borderline diagnosis.

Writing in a book about shame, Bradshaw said that his own study of psychiatrist James Masterson's work on borderline personalities, and the experience of watching Masterson's working films (Olive Tree Productions, 1988a, 1988b), convinced him that "there is minimal difference in the treatment of some toxically shame-based people" and Masterson's treatment of BPD. Bradshaw says he is convinced "that Masterson's Borderline Personality is a syndrome of neurotic shame" (Bradshaw, 1988, p. 15).

In a doctoral dissertation, Laurie M. Hoover (1989, p. 5) said that research concerning adult children of alcoholics (ACOAs) and individuals with BPD may seem far apart theoretically, but there appears to be a large amount

of overlap in descriptions of their characteristics. Her research was conducted with 124 subjects recruited from ongoing adult children of alcoholic groups in Nebraska and Kansas. The group leaders had been identified through referrals from the Lincoln Council on Alcoholism and Drugs and through networking.

Hoover used the *DSM-III-R* (APA, 1987) criteria for BPD and measured it with the *Borderline Syndrome Index* (BSI), a 52-item, forced-choice, self-report questionnaire that was created by Conte, Plutchik, Karasu, and Jerrett (1980). The BSI has Kuder-Richardson Formula 20 reliability of .92. Hoover found that "a significantly higher proportion of BPD was discovered in the adult children of alcoholics population ($p < .05$) than in a hospitalized population" (Hoover, 1989, pp. 91-92). She suggested a need for further research to examine the similarities between ACOAs and BPD.

Outcome Studies

If it is correct that the characteristics of BPD and CODC overlap, might it not be true that the possibility of benefiting from treatment should be the same for both groups? However, there appears to be more hope for the treatment of persons diagnosed with BPD (Masterson, 1976, p. 353; Stevenson & Meares, 1992; Stone, 1990, p. 205) than for persons "treated" for CODC whose leading practitioners

describe as having a "dread" or even lifelong "disease" (Beattie, 1989; Gravitz & Bowden, 1985; Mellody, 1989; Schaef, 1986; Wegscheider-Cruse, 1984.)

One possible explanation of this difference might be the level of training of the clinicians administering the treatment. It was discussed above that many individuals who purport to treat CODC do not have even bachelor's level academic degrees but rather may have a certificate indicating that they have taken a prescribed number of hours of training in some aspect of chemical dependency treatment. Since the persons who are treated for BPD most likely are being seen in a mental health setting where standards are higher, it is reasonable to assume that they are being seen by therapists with at least a master's degree and probably a license, ensuring that they have met the standards decreed by their profession and required by a state licensing board in order to protect the interests of the public they serve.

The prospect for successful treatment of BPD is encouraging (Barley et al., 1993; Pildis, Soverow, Salzman, & Wolf, 1978; Pressler, 1990). The most extensive outcome study encountered thus far was the "PI-500," which is verbal shorthand for a long-term follow-up study of patients consecutively admitted to the "Long Term Unit" at the New York State Psychiatric Institute (PI) between 1963 and 1976. Of the 550 patients in the study, they succeeded in tracing 502 (Stone, 1990; Stone, Hurt, & Stone, 1987).

Clinical recovery was common among this population. The average age at admission had been 22. "To emerge in one's 30s or 40s as either 'good' (Global Assessment Scale [GAS] score of 61-70) or 'recovered' (GAS score > 70) was the rule rather than the exception" (Stone, 1990, p. 205).

Stevenson and Meares (1992) presented an outcome study of the effectiveness of an identifiable form of psychotherapy on a group of 30 BPD outpatients with severe Personality Disorder as diagnosed by a team of three independent psychiatrists using the Diagnostic Interview for Borderline Patients and other criteria. In addition, the potential subjects had to display persisting social dysfunction such as unemployment for more than 12 months, absence of or severely dysfunctional interpersonal relationships, or antisocial behavior. All of these patients had been unsuccessfully treated using other forms of therapy, including drugs and ECT, for a period of not less than 6 months. The patients in this study were treated twice weekly for a year by closely supervised trainee therapists in a maturational therapy "based on the notion that borderline personality disorder is a consequence of a disruption in the development of the self" (Stevenson & Meares, 1992, p. 358).

The therapeutic technique they used is based on an analogy Freud once made between transference and a child's play space. Meares (Stevenson & Meares, 1992) suggests that

the mental activity underlying play is essential to the development of self. The therapist's task is to establish that kind of mental activity for the patient whose personality development was severely disrupted. The Cornell Index was used to provide a self-report rating of symptoms. Objective behavioral measures were collected en bloc for the entire year preceding and the year following therapy. Information was obtained from the patient, friends or relatives, medical records, and referral sources.

Stevenson and Meares (1992, p. 359) believe the first main task of the therapist is to "establish the enabling atmosphere in which the generative mental activity can arise" and the second task is to detect empathic failures and "focus with the patient on his or her experience at the moment of the failures, and then to allow these experiences to be the starting point of experiential explorations."

They reported "there was a marked and statistically significant improvement on all seven objective behavioral measures over the 12 months following therapy compared with the 12 months before therapy" and the "most frequently observed changes were reductions in impulsivity, affective instability, anger, and suicidal behavior" (Stevenson & Meares, 1992, p. 360). Moreover, at the end of the year of treatment, 30% of the patients no longer fulfilled the DSM-III criteria for borderline personality disorder. The

improvement was shown to have been maintained at follow-up 12 months later (Stevenson & Meares, 1992, p. 361). Dr. Meares wrote (personal communication, August 21, 1992): "Unfortunately our more recent follow-up data has not yet been put together. We are also about to embark on a larger study of the treatment of Borderline Personality, but this will produce significant data a few years hence".

As Stone concluded, it appears that some BPD patients do conquer their need for sensational activity, their adolescent wildness, and many mature into highly productive citizens with emotionally rich, rewarding lives (Stone, 1990, p. 205). These individuals appear to validate James Masterson's opinion, expressed more than 15 years ago, that the fruits of successful psychotherapeutic labor with the borderline adult are rich and varied for both patient and therapist. When freed from the chains of childhood conflicts, Masterson believes that the BPD patient can grow and discover for himself or herself "the magic and mystery of life" which was, as Freud said, "to love and to work" (Masterson, 1976, p. 353).

Stone (1990, p. 275) reminds us of Lawrence Kolb's list (1982, p. 221) of personality assets that help offset the effects of pathological traits; he adds to it one item: "charm." Related primarily to the external world are courage, curiosity, and flexibility; primarily task-directed and also related to constancy in relationships are

commitment, perseverance, and responsibility; and primarily related to personal relationships are humor, empathy, and trust; and Stone's own addition of charm (Kolb, 1982, p. 221, quoted in Stone, 1990, p. 275).

However, Stone also observed that borderlines with few if any of those qualities, or any of what he called "natural advantages" such as beauty, talent, wealth, social position, or fame, sometimes attained unexpected success. In pondering why some very ill patients get well and others not so ill do not, he concluded that

> we must look beyond parochial controversies about the efficacy of this or that modality, this or that school of thought, if we are to account for these peculiarities. It is here, I feel, that the balance of the patients' pre-existing and seemingly extraneous balance of advantages verses [sic] disadvantages can explain some of the variance. (Stone, 1990, p. 194)

Summary

In this chapter we examined the phenomenon of CODC and noted how public awareness of the topic appears to have been fueled by skillful marketing of self-help books described by one critic as remarkable for their "sameness" and "earnest fatuity." We looked beyond the stereotypical borderline patient to higher functioning individuals with IQs one or two standard deviations above the mean. We noted that experts declined to include CODC as a diagnosis in the latest DSM and examined statements about the similarity of CODC and BPD written by two leading proponents of CODC,

Bradshaw and Cermak. The similarity was confirmed in Hoover's doctoral dissertation. I suggested that if they are indeed similar, the outcome of treatment should be similar. The fact that BPD treatment appears to be more effective than treatment of CODC may be a reflection of inadequate training and credentialing of CODC counselors.

CHAPTER 5

METHODOLOGY

In this study I was interested in learning if there is an area of overlap of BPD and CODC where people who think of themselves as "codependent" and function well enough to read CODC literature and/or participate in CODC groups may have some of the characteristics associated with BPD.

These ideas are illustrated with extensive citations from the literature, with particular emphasis on work published during the 1980s because that was the period when interest in co-dependence reached its greatest popularity. In addition, supplementary supporting evidence for this topic was gathered by means of two self-report instruments; one was completed voluntarily and anonymously by co-dependent persons and the other was completed voluntarily and anonymously by clinicians.

One characteristic the CODC and BPD populations have in common is that many of the individuals who comprise them are ill now because they were treated not as people but as objects, many of them as sex objects, beginning in very early childhood. When I read the words "borderline" or "co-

dependent" I can visualize the faces of dozens of individual human beings who have poured out their stories and their tears in my office. Because I am acutely aware that we are talking about people, not "diseases," it is important for me to say that I agree with Elliot Eisner (1991, p. 4) who wrote: "I make no apology for the personal tone that I hope comes through on these pages. Although my words were prepared on a computer, they were created by a person. I want that to show."

Procedures Utilized

The question of whether there is overlap of CODC and BPD was approached in three ways.

1. A graphic comparison was made of characteristics common to BPD and CODC, using a list compiled by Dr. Eda G. Goldstein.

2. A survey was conducted of clinicians to see what they believed to be the characteristics of CODC and BPD.

3. A survey was done of clients identified as co-dependent using an instrument designed to assess BPD in order to see if they perceived themselves as having characteristics of BPD.

Research Question #1

Characteristics Common to BPD and CODC

Question #1: Is there an area of overlap between what pop-psychology calls CODC and the clinical literature

calls BPD?

What I believe to be the crux of this study, the evidence for the similarity of BPD and CODC, is depicted in the form of an item-by-item comparison of passages from the two bodies of literature (see chapter 6) organized according to the clinical categories outlined in chapter 3 of *Borderline Disorders: Clinical Models and Techniques* (1990) by Dr. Eda G. Goldstein. The characteristics Goldstein utilizes were selected as reference points because they offer a broad inclusive picture of the borderline personality as it is described by a representative range of the various theoreticians who have written on the subject.

The characteristics are: Identity Disturbances, Splitting and Other Related Defenses, Reality Testing and Psychotic-Like Features, Problems in Impulse Control, Problems in Anxiety Tolerance, Problems in Affect Regulation, Negative Affects, Problems in Self-Soothing, Fears of Abandonment, Problems in Self-Cohesion, Problems in Self-Esteem Regulation, Superego Defects, and Intense and Unstable Interpersonal Relationships (Goldstein, 1990, pp. 30-52).

As far as the archival research is concerned, the overwhelming quantity of clinical and popular material available placed limits on the extent of the endeavor. Clarkin, Marziali, and Munroe-Blum (1991) suggest that BPD is by far the most heavily researched of the personality

disorders. And a glance at the self-help and pop-psychology sections of any bookstore will verify the popularity of CODC (Morgan, Jr., 1991). Therefore, due to the enormous quantity of material in both fields, the reviews of both bodies of literature are illustrative, not exhaustive.

Research Question #2

Clinician Survey

Question #2: If there is some overlap of CODC and BPD, is the overlap recognized by practicing clinicians?

As the first step in finding an answer to this question, I wanted to know what characteristics clinicians believe are indicative of BPD, whether they think the same ones are indicative of CODC, and therefore whether or not they believe there is overlap of any characteristics of CODC and BPD.

Having recently attended several seminars and participated in numerous discussions on the transition from DSM-III-R to DSM-IV, I have discovered that many of my colleagues' knowledge of BPD seems to be limited to a vague familiarity with the diagnostic criteria in the edition of DSM that was current during the time they were being trained. Many of the clinicians I have spoken with are as unfamiliar with the large body of literature describing the lively differences of opinion on exactly what characterizes BPD as I was before I began my research. I was curious to

know what characteristics clinicians associate with BPD and what characteristics, if any, they associate with CODC.

Therefore, I created a brief, anonymous survey for clinicians to determine what *they believe* (not what the criteria say) are characteristics of CODC and of BPD, and whether they believe any characteristics of the two overlap. My one-page self-report instrument was devised specifically for this purpose. From its origin as my project in the Techniques of Scale Development class in the Spring of 1993, it has gradually evolved to its present form. The 10 items on the instrument are all quotations from recognized BPD authorities such as Eda G. Goldstein, Ph.D., John Gunderson, M.D., Otto F. Kernberg, M.D., and James F. Masterson, M.D. Thus, whenever the CODC column is checked it is an automatic endorsement of a BPD characteristic.

In addition, five (5) of the questions on the instrument relate specifically to the identity cluster: questions #5, #6, #8, #9, and #10. It was anticipated that fewer clinicians would correctly identify these items as borderline characteristics than some of the questions relating to the affective and impulsive clusters.

The cluster analysis studies I have read so far were conducted during the time period when DSM-III-R was in use. Since that time the revised DSM-IV has been published and it gives even more weight to the identity cluster items. The criteria in DSM are numbered according to relative

significance in both editions with #1 being the most significant and #8 being the least significant in making the diagnosis. It is interesting to note that two of the three criteria that delineate the identity cluster moved up very significantly to first and third place in the hierarchy, and the third remained the same: DSM-III-R criterion #6 (identity disturbance) was shortened and made less restrictive as criterion #3 in DSM-IV; DSM-III-R criterion #8 (frantic efforts to avoid abandonment) became criterion #1 in DSM-IV. DSM-III-R criterion #7 (chronic feelings of emptiness) remained the same but dropped the words "or boredom."

Derivation of the Items

Item #1 represents *control*, which comes under the category of *splitting* (Goldstein, 1990, p. 36). Item #2 represents *anger* and *control*, which are both in the category of *splitting* (Goldstein, 1990, pp. 44-47). Item #3 represents *self-esteem regulation* (Goldstein, 1990, p. 49). Item #4 represents *denial* and *control* in the category of *splitting* (Goldstein, 1990, p. 39). Item #5 represents a cycling back and forth between *clinging* to a loved one and *distancing* from him or her that I call *rollercoastering*; this is indicative of *fear of abandonment* (Goldstein, 1990, p. 46). Item #6 also represents *rollercoastering* or *fear of*

abandonment (Masterson, 1988, p. 77); Item #7 represents *anger* in the *splitting* category (Masterson, 1988, pp. 78-79). Item #8 represents *perfectionism,* which is an indication *of identity disturbance* (Goldstein, 1990, p. 31). Item #9 represents *intellectualizing,* which indicates *identity disturbance* (Masterson, 1988, p. 87). Item #10 represents *external referenting,* which indicates *identity disturbance* (Goldstein, 1990, p. 31). Items #3, #5, #6, #7, and #8 are also related to the category of *intense and unstable interpersonal relationships.* The instrument and a key showing the source of the items are attached as part of Appendix E.

The Sample

To fine tune the instrument, originally it was sent to 19 clinicians in a variety of practice settings in several states, asking them to distribute it to their colleagues. This yielded a return of 37 completed forms. Feedback from that mailing suggested that the word "totally" be deleted from the first item. This item was not a part of the Identity Cluster that was the main focus of inquiry, and thus the change does not impact the results of this study.

The Kentucky Psychological Association (KPA) granted permission for the revised version to be distributed at their Annual Meeting from November 2-4, 1995. I was told that 300 students and mental health professionals were

expected to attend the meetings. I had 300 forms printed and handed out about 150 of them. Of these, 101 completed forms were placed in the collection box, bringing the final tally to 138, including the ones in the original mailing. Responses to the survey were analyzed and are reported in chapter 7 with my interpretation of the results.

Research Question #3

Client Survey

Question #3: How would co-dependent persons score on a BPD test instrument?

Borderline Syndrome Index

For additional supporting evidence I have documented the anonymously self-reported borderline characteristics of co-dependent persons by analyzing their scores on the 52-item Borderline Syndrome Index (BSI) which was developed by Conte, Plutchik, Karasu, and Jerrett (1980).

The 1980 Study

The BSI authors provided a percentile table of preliminary norms based on data obtained from the four groups in their study. The sample sizes of the three clinical groups were 35 borderline, 36 depressed, and 20 schizophrenic. In the original study 10% of BPD patients obtained a score of 16 or less, whereas 95% of normal subjects obtained a score of 16 or less. "Approximately

half of the borderline patients obtained a raw score of 25 or less," yet "almost 100% of the normal subjects obtained such a score" (Conte et al., 1980, p. 433).

All of the subjects were adults. The normal group was composed of 50 volunteers who included day and evening college students and nonfaculty staff members at Bronx Municipal Hospital Center, Bronx, New York. None of them had any previous history of psychiatric hospitalization. The BPD group consisted of 35 outpatients who exhibited at least five of the eight operational characteristics for borderline personality disorder listed in DSM-III. The diagnoses were made by psychiatric residents in their second year of training and were confirmed by supervising psychiatrists (Conte et al., 1980, p. 430).

The reliability of the BSI, as determined by the Kuder-Richardson Formula 20, was .92, which indicates high internal consistency (Conte et al., 1980). *Post hoc* comparisons (Scheffe) showed the borderline group's mean score of 26.31 (SD = 8.27) was significantly higher than the mean score of 5.92 (SD = 5.5) for the normal group at better than the .001 level.

My Study

Permission to use the BSI in my research was granted by the lead author, Hope R. Conte, Ph.D., in a telephone conversation on October 16, 1995, and confirmed by a letter

dated October 17, 1995. In addition, as she had for Laurie Hoover in the dissertation cited previously, she granted me permission to change the name of the instrument to the more innocuous name Anonymous Personality Style Inventory (APSI). The APSI is appended, as is a sample of the cover letter for persons completing the form and a sample of the letter that was sent to area treatment centers, hospitals, and agencies requesting permission to have it offered to individuals who volunteer to complete it at their facilities. Also attached are the letters that were sent to ACOA, Al-Anon or CoDA groups that expressed interest following an initial telephone inquiry (see Appendix E). As a result of the above correspondence, cooperation was obtained from one regional hospital with a substance abuse and co-dependence treatment facility, two community mental health centers that offer services to the co-dependent population, and one Al-Anon group.

In the present study a raw score of 16 is used as the cutoff score for the normal range. The committee agreed that an acceptable size for this study of co-dependent persons would be in the range of from 20 to 36, or as many as time and circumstances permit. Although an unusually snowy winter at first kept the client census low, eventually a sample of 44 was collected. Since there are no diagnostic criteria for CODC, the criteria used for this study were the same as the criteria for attendance at a CODC support group

such as Al-Anon, namely identification with the group. All of the persons who completed the APSI were volunteer adults who were participating in one of the co-dependence programs at Baptist Regional Hospital, Kentucky River Community Care, or one Al-Anon group that participated. They identified themselves as co-dependent, or stated that they had been told they were co-dependent by someone else such as a relative, friend, or counselor. The volunteers did not have to agree with that opinion. Responses to the survey were analyzed and are reported in chapter 7 with my interpretation of the results.

The Eastern Kentucky Sample

In September 1995 I accepted a job in the remote, mountainous "coal fields" of eastern Kentucky. Most of the client survey information was gathered at community mental health centers in Hazard and Jackson, Kentucky. These communities are county seats but Jackson's population is only 2,466 and Hazard's is 5,416.

In addition to the geographic isolation there is cultural and economic deprivation. Jobs are scarce and wages are low. There are no bookstores. There are many common products you cannot buy here because this is beyond trucking distance from their distribution centers. What you *can* buy is very expensive. Gas costs 20 cents more per gallon; a brand of International coffee costs over a dollar

more per 8 oz. can than it costs in Chattanooga. Hazard is 2-1/2 hours from Lexington, the nearest vestige of what I think of as "civilization."

While living here has been merely inconvenient, expensive, and annoying for me, life here is frequently miserable and life-threatening for the largely poor and poorly educated people who call it home. Several clients in my caseload come from families of 12 to 20 children. These clients are now on welfare, and they carry on the tradition of producing large families, at taxpayer expense. This exemplifies the low side of the tail so eloquently described in Herrnstein and Murray's (1995) best-seller, *The Bell Curve: Intelligence and Class Structure in American Life.*

This is partly due to geography. I describe the terrain around Hazard as looking like a bunch of capital Ms squashed together because although the mountains are not high, they are steep and so close together there are no valleys and no vistas. They are so steep it is difficult to build on their sides so a few wealthy people build on the ridges and most people huddle in the narrow V-shaped areas at the bottom. Even major federal and state highways are two lanes with occasional passing lanes. Many secondary roads are very narrow or even one lane and treacherous.

Local people call the areas between the mountains "hollers." A majority of my clients live in hollers with their extended family and have almost no friends. About 25%

of the population has no telephone service. In my limited experience I have not found many people who get along with their family. This may be due to the highest incidence and greatest severity of alcoholism, drug use, sexual abuse, and physical violence that I have ever encountered. Rape and murder are commonplace.

Although it is not a common diagnosis in the general population, Intermittent Explosive Disorder is relatively common in men out here. Post Traumatic Stress Disorder is a very common diagnosis in women here, usually due to severe childhood sexual abuse and/or domestic violence. As I noted earlier, the literature reviews showed that childhood sexual abuse has been associated with BPD and CODC.

Summary

A preliminary review of the literature had suggested that some individuals who are considered to be co-dependent may have some of the same characteristics as individuals who have been diagnosed with BPD. A qualitative approach was deemed appropriate to research whether there is an area of overlap of CODC and BPD.

I obtained the primary documentary evidence by conducting archival research of the extensive pop-psychology literature on CODC and the equally extensive clinical literature on BPD. To present the findings I made a side-by-side comparison of the two bodies of literature utilizing

the characteristics of BPD identified by Eda G. Goldstein.

I obtained secondary supporting evidence of the similarity of CODC and BPD by conducting anonymous self-report surveys of clinicians and co-dependent persons. I created my own instrument for clinicians, designed to determine their knowledge of characteristics of borderline personality disorder in general, and specifically the criteria for the identity cluster. I obtained and analyzed 138 responses.

I obtained permission from the author to distribute the 52-item self-report Borderline Syndrome Index to co-dependent persons, using the more innocuous title of the Anonymous Personality Style Inventory. I analyzed the scores of 44 volunteer CODC subjects on this instrument and compared them with the original 1980 scores of normal persons and persons diagnosed with BPD.

CHAPTER 6

CHARACTERISTICS COMMON TO BPD AND CODC

Introduction

The material in this chapter provides the answer to Research Question #1: Is there an area of overlap between what pop-psychology calls CODC and the clinical literature calls BPD?

This is the "backbone" of the dissertation. It is the skeletal structure or schema that I created to bring some order to the broad diversity of topics and the vast difference in terminology, which makes both the BPD and CODC literature difficult to comprehend and very difficult to compare. Because the need to organize a large mass of diverse material came first and was the basis for all that followed, the resulting chapter 6 is referred to as the primary documentary evidence on which the entire premise of the dissertation is based.

Some of the material in this chapter was distilled from the broader range of material in the two chapters which constituted the reviews of both bodies of literature, chapter 2 on CODC and chapter 3 on BPD. In general the

quotations in this chapter are more detailed than those in the previous two chapters. Also, there are numerous additional quotations here that were not germane to the discussions in the previous chapters but are relevant to the categories and topics utilized by Goldstein (1990), as described below.

In this chapter the characteristics of CODC and BPD are classified according to the following categories used by Dr. Eda G. Goldstein to describe the borderline personality: Identity Disturbances, Splitting and Other Related Defenses, Reality Testing and Psychotic-Like Features, Problems in Impulse Control, Problems in Anxiety Tolerance, Problems in Affect Regulation, Negative Affects, Problems in Self-Soothing, Fears of Abandonment, Problems in Self-Cohesion, Problems in Self-Esteem Regulation, Superego Defects, and Intense and Unstable Interpersonal Relationships (Goldstein, 1990, pp. 30-52).

For my purposes, the appeal of using her categories is that she is inclusive, not exclusive. That is, she does not limit herself to any one of the perspectives such as that of Kernberg or Gunderson or Masterson, but draws upon a variety of models to "discuss and illustrate the main features of borderline disorders as they are experienced by the patient, significant others, and in the clinical situation" (Goldstein, 1990, p. 30). In some of her categories where a variety of topics were addressed within

the category I have broken them down into subgroups.

This chapter consists of a side-by-side presentation of descriptions by recognized authorities in the fields of CODC and BPD articulating the characteristics that one body of literature says is diagnostic of BPD and another body of literature says is "diagnostic" of CODC. This comprises the primary evidence of the similarity between BPD and CODC because all of my subsequent research was based on this framework. It is particularly compelling because it consists of quotations from authorities in both fields, not just my interpretation of what they said.

Because there is quite a lot of overlap and interrelatedness of categories I have tried to limit the number of times I use duplicate quotes to illustrate more than one of the characteristics. For example, the characteristic I call "rollercoastering" is described in the section on Fear of Abandonment but it could just as well be placed in the section on Intense and Unstable Relationships.

During the course of this research I have noticed that much of the emphasis in co-dependency treatment is on healing and/or re-parenting a "child within" or an "inner child" (Clarke & Dawson, 1989; Oliver-Diaz & O'Gorman, 1989; Weiss & Weiss, 1989) whose development was arrested or delayed at the age/stage when some trauma occurred. And I have noticed also that numerous approaches to treatment of the borderline client came from self psychology and various

object-relation theories and may involve integration of the "real self" (Masterson, 1985, 1988) whose development was similarly impaired.

Are the "child within" or "inner child" and the "real self" the same thing? This is an example of the confusion that can occur in dealing with the vocabulary of these two fields where often we appear to be comparing apples with oranges, only to suspect as our understanding deepens that they may be two ways of describing the same thing.

Because the credibility of my work depends on my ability to detect and make the reader aware of the degree of agreement between numerous authors who are using different frames of reference, I have cited page numbers and used direct quotations far more frequently than is customary in psychological literature. This was done in order to ensure accuracy and to permit other scholars to check my work.

Another way I have tried to clarify the topic is to describe the BPD characteristics in terms as close as possible to the terms used to describe CODC. To accomplish this, Darwin Dorr (personal communication, June 5, 1992) recommended using terminology from the writings of James F. Masterson because his style is more easily comprehended by people without psychiatric training than works by other authors who are also authorities in this field. Masterson's terminology in *The Search for the Real Self* (1988), a book

written for laymen, is a good match with the terminology used in most of the CODC books that are specifically written in even more simplified, nontechnical language for a lay audience. In addition, I used the terminology employed by Eda G. Goldstein in *Borderline Disorders: Clinical Models & Techniques* (1990).

Material from the literature on BPD is in standard type; that from the CODC literature is in boldface type.

Identity Disturbances

Introduction

BPD References:

The DSM-III-R utilizes the following criteria as evidence of identity disturbance: "marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values" (American Psychiatric Association, 1987, p. 347).

The self-concept of BPD individuals can be highly inflated (perfectionistic) or depreciated, or may alternate between them; "borderline individuals have difficulty acknowledging any characteristics, thoughts, or feelings that violate their particular views of themselves" (Goldstein, 1990, p. 31).

CODC References:

Subby (1987, p. 55) notes that "co-dependency is the product of delayed or interrupted identity brought about by the practice of dysfunctional rules."

External Referenting

BPD References:

"Some borderline individuals literally take on the identities of certain others with whom they associate. They define themselves in terms of how others see them. Their interests, values, modes of dress, and mannerisms shift as the nature of their attachments change" (Goldstein, 1990, p. 31).

CODC References:

Schaef (1986, pp. 44-52) places external referenting first on her list of CODC characteristics. She says co-dependents feel they have no intrinsic worth. They derive their meaning from other people; they are externally referented and will do almost anything to be in a relationship. A big part of this is done by impression management, which is a form of control. They need other people to validate them; it is absolutely essential that others perceive them the way they want to be seen. They ask themselves "What will other people think?" They are

insecure and have low self-esteem; they are forever saying "I'm sorry" but they really mean they are sorry they exist at all.

Beattie (1987, p. 41) says co-dependents desperately need love and approval from others and latch onto anyone they think can provide happiness for them. They center their lives around these people.

Identity Diffusion

BPD References:

Identity diffusion is the lack of integration of the concept of the self or of significant others and is evidenced in the patient's experience of chronic emptiness, contradictory self-perceptions and behavior, and impoverished and contradictory perceptions of other people, and the difficulty the patient has in communicating their significant interactions with others to their therapist (Kernberg et al., 1989, p. 5).

CODC References:

Brown (1988, p. 181) says ACOAs "cannot negotiate emotional separation because they lack an adequate base of attachment from which maturation and separation can occur. . . . The major roadblock to autonomous development and separation is the necessity to develop an independent

identity."

Schaef (1986, pp. 57-8) describes the co-dependent as being out of touch with his or her own feelings while thinking he/she knows what other people feel and being preoccupied with meeting another person's expectations. The co-dependent often does not know what he or she feels or wants.

Emptiness (Loneliness)

BPD References:

According to Gunderson and Kolb (1978, p. 795), "loneliness and emptiness were very frequent complaints and quite specific to the borderline patients." A later study (Gunderson et al., 1991, p. 346) showed that "emptiness is highly discriminating for the BPD diagnosis ($p < .001$) whereas boredom is not."

CODC References:

Stephanie Brown refers to the co-dependents' pathological clinging to all-or-none thinking to cover the painful recognition of their isolation and aching loneliness (Brown, 1988, p. 109).

Beattie (1987, p. 37) says they "feel bored, empty, and worthless if they don't have a crisis in their lives, a problem to solve, or someone to help."

Intellectualizing

BPD References:

Masterson found that

> they [BPDs] may use a high IQ and a tendency to intellectualize to enter a profession such as law, medicine, architecture, or accounting. Closer examination will probably reveal that the motivation for the work is not self-expression but meeting the expectations of others. For some there is the goal of attaining an illusion of closeness. . . . Any career such as reporter, photographer, psychiatrist, or minister which requires professional detachment places one in a position to project oneself into others' lives and identify with life dramas being played out there without fully committing oneself to the same emotions and activities in one's own life. (Masterson, 1988, p. 87)

CODC References:

Sharon Wegscheider-Cruse says intellectualizing is a basic defense of co-dependents (Wegscheider-Cruse, 1987, p. 41).

Schaef describes co-dependents' thinking disorders: she says they are ego-oriented, confused, obsessive, and dualistic; they rationalize; they exhibit overreliance on linear, logical, analytic thought processes (Schaef, 1986, pp. 83-85, 1987, pp. 61-64).

Perfectionism

BPD References:

E. G. Goldstein (1990, pp. 41-42) says borderline individuals may protect an idealized and perfectionist

self-image through denial and/or splitting off of angry or other unacceptable feelings that sometimes break out, without warning, under circumstances that shatter their fragile self-concept or self-cohesion.

According to E. G. Goldstein (1990, p. 48), the vulnerable self-regard of BPD patients may be contingent on their ability to live up to their own perfectionistic standards.

CODC References:

Beattie (1987, p. 38) notes that co-dependents "expect themselves to do everything perfectly."

Larsen (1985, p. 24) says: "Not only must the 'things' around them be perfect, but so must the people. They are absolute masters at finding fault."

Co-dependents have unrealistic expectations of themselves and of others; they expect perfection of themselves yet also feel they cannot do anything right. They are afraid of making mistakes (Beattie, 1987, pp. 38-39, 1989).

Sexual Problems

BPD References:

Confusion regarding sexual orientation or sexual preference was mentioned as a common source of concern or anxiety for BPD patients (Goldstein, 1990; Masterson, 1988).

Masterson (1988, p. 117) notes the endless variation in the sexual habits of BPDs. Some function well only when there is no continuity, in one-night stands. Some respond only to partners they are not emotionally involved with, and others are serious only about those with whom they are not being sexual.

Several authors mentioned the increasing awareness of childhood sexual abuse as an important issue in BPD (Herman, Perry, & van der Kolk, 1989; Morrison, 1995; Winchel & Stanley, 1991, p. 309).

CODC References:

Woititz (1985, pp. 59-70) devotes an entire chapter to sexual issues, starting with confusion about one's sexual identity and sexual orientation, presenting those as serious problems for co-dependents.

Co-dependents withdraw emotionally from their partner; they have sexual fantasies about other people; they are afraid of losing control during sex; they consider or have extramarital affairs; they make up reasons to abstain; they refuse to enjoy sex because they are so angry at their partner (Beattie, 1987, p. 44, 1989).

Janet Woititz says that a history of incest is not uncommon in co-dependents (Woititz, 1985, pp. 66-69).

(See Problems in Impulse Control, Sexual Behavior.)

Splitting and Other Related Defenses

Introduction

BPD References:

A child who fails to achieve object constancy will go through life relating to people as parts--either positive or negative--rather than whole entities; he will be unable to maintain consistent commitment in relationships when he is frustrated or angry (Masterson, 1988, pp. 78-79).

Bond, Paris, and Zweig-Frank (1994) note that anger, anxiety, and empty depression overwhelm patients with BPD.

Lumsden (1993) explains splitting as a function of the BPD patient's characteristic distortion of time, which he describes as living in a truncated existential time frame (TTF) or living almost exclusively in the present and being "unable to readily access previously experienced affect in regard to significant others."

Kernberg suggested that borderline patients' core difficulty lies in their inability to bring together and integrate loving and hating aspects of both their self-image and their image of another person. Kernberg's observation was that these patients cannot sustain a sense that they care for the person who frustrates them. Kernberg saw this characteristic failure in the achievement and tolerance of ambivalence and in the modification of affects as diagnostic (Shapiro, 1978, p. 1307).

Borderline individuals cannot simultaneously experience contradictory feeling states, such as love and anger or admiration and disappointment. Thus, they tend to perceive themselves and others in extreme or unidimensional ways. Often their feelings and perceptions shift without any precipitant, or as a result of seemingly minor frustrations so that someone who is viewed as all 'good' suddenly is seen as all 'bad' (Goldstein, 1990, p. 35).

Generally unconcerned about the blatant contradictions in the ways they experience themselves, borderline individuals do not worry about or try to resolve these discrepancies. They rationalize them or become angry or defensive if these are pointed out (Goldstein, 1990, p. 36).

CODC References:

In treating ACOAs, Brown (1988, pp. 103-104) says

> the defenses required for survival and attachment in the family become the essence of the false self, also developed in the interests of meeting parental needs and of maintaining attachments. As such, the individual has no sense of anything beneath the defensive core and cannot step out of it to reflect on it. Very often the process of treatment involves a central focus not only on 'breaking down' defenses but on breaking down the false self.

Co-dependents have conflicting views of themselves and others. Beattie (1987, pp. 42, 44-45) says they "don't say what they mean, don't mean what they say, don't know what they mean"; they combine passive and aggressive

responses, they laugh when they feel like crying, they vacillate in decisions and emotions, they are both responsible and irresponsible.

Beattie (1987, p. 38) says co-dependents "get angry, defensive, self-righteous, and indignant when others blame and criticize the codependents--something codependents regularly do to themselves."

Control

BPD References:

Goldstein refers to the "omnipotent control, in which a person with a highly inflated sense of self attempts to control others totally" (Goldstein, 1990, p. 36).

Masterson (1988, p. 126) describes a client for whom control, fear, and fantasy were the central themes of life.

CODC References:

Brown (1988, p. 115) says,

> In all of our work, we have been amazed at the repeated emphasis on control, identified as a problem in its own right, and as a structure for interpreting self and other. In examining difficulties related to establishing and maintaining intimate relationships, the need for "control" and the impact of control as a structure are central. See her entire section on control, pp. 115-137, for more details.

Schaef (1986, pp. 56-7) says that as their life situation becomes more chaotic, the co-dependent tries to exert more and more control. They believe they can control

other people's perceptions, behavior, and thoughts.

Denial and Dishonesty

BPD References:

E. G. Goldstein (1990, p. 39) warns that therapists should be alert to what clients may not share as well as what they reveal in treatment. She says they tend to keep important and possibly very troublesome issues out of their treatment sessions. She suggests that, with the client's permission, it may be necessary to maintain contact with the client's family and close friends; especially if there is a tendency to self-destructive behavior.

CODC References:

They tend to edit or withhold certain information from anyone they want to impress, even their therapist (Vannicelli, 1989, pp. 142-146).

Black (1981, p. 39) explains that ACOAs learned to lie from their families because enabling parents "don't want to acknowledge that the problem [alcoholism] exists in the first place." The child's mother would say she was "fine" but her tone of voice and body language depicted misery.

Co-dependents "become afraid to let themselves be who they are"; they "lie to themselves"; they "lie to protect and cover up for people they love"; they "lie to

protect themselves" (Beattie, 1987, pp. 39-40, 42).

Schaef (1986, p. 59) says "lying--to get yourself out of an uncomfortable spot--is characteristic of the co-dependent."

Co-dependents ignore problems, pretend things are not as bad as they are, stay so busy they do not have time to think. They believe their own lies (Beattie, 1987; Schaef, 1986).

In group therapy a client can be so oblivious of his own problem that he can be eagerly helping another person sort out closely related issues and not recognize until later the relevance to his own experience (Vannicelli, 1989, pp. 16; 142-146).

Manipulation

BPD References:

Gabbard (1989) says BPD patients often manipulate hospital staff, setting one clinician or staff member against another. This is a form of control to defend against their fear of abandonment.

CODC References:

Beattie (1987, p. 40) says they think they know best how things should turn out and how people should behave; they "attempt to control events and people through

helplessness, guilt, coercion, threats, advice-giving, manipulation, or domination." They are afraid to let people be themselves and to allow things to happen naturally.

Reality Testing and Psychotic-Like Features

Reality Distortion

BPD References:

E. G. Goldstein (1990, p. 40) reports that

> borderline individuals distort reality to some degree, but their misperceptions are rarely bizarre. For example, they may be highly suspicious of friends and associates, fail to recognize important qualities in others' dealings with them, or impute malevolent motivations to those close to them. When other alternatives are presented or when their primitive defenses are interpreted, they can usually consider that they may be misperceiving the situation.

CODC References:

Brown (1988, p. 41) reports that ACOAs "learned not to test reality, not to take action, because it would not be congruent with the parents' reality."

Problems in Impulse Control

Introduction

BPD References:

E. G. Goldstein (1990, p. 41) writes: "Borderline individuals' impulsiveness contributes substantially to the turbulent, unpredictable, and crisis-ridden nature of their lives. . . . Impulsive individuals who utilize splitting,

and thereby come to view a friend, lover, or therapist who frustrates or disappoints them as all 'bad,' may break off their relationships suddenly."

E. G. Goldstein (1990, pp. 41-42) found that some borderline individuals are overcontrolled except for occasional outbursts. They protect an idealized and perfectionist self-image through denial and/or splitting off of angry or other unacceptable feelings that sometimes break out, without warning, under circumstances that shatter their fragile self-concept or self-cohesion.

CODC References:

Woititz (1985, pp. 98-99) cautions that impulsivity is one of the ACOAs biggest enemies. The tendency to lock themselves into a course of action without thinking about alternative behaviors or possible consequences leads to loss of control over one's life. Co-dependents often feel anger as they struggle to clean up messy situations or lie their way out of them.

Sexual Behavior

BPD References:

Betty Head found that impulsive sexual behavior may be one kind of impulsiveness that is specific to borderlines (Head, 1991).

CODC References:

Sitting around the tables at Twelve Step group meetings I heard a lot of confessions of sexual promiscuity. This reading from a book of daily meditations for ACOAs speaks volumes: "I will even learn how to say 'No' to sexual invitations and still feel okay" (Lerner, 1985, p. 337).

Another meditation book, for co-dependents, has this entry: "We do not have to allow our sexual energy to control us or our relationships. We can establish and maintain healthy, appropriate boundaries around our sexuality. We can discover what that means in our life" (Beattie, 1990, pp. 338-339).

(See also Identity Disturbances, Sexual Problems.)

Problems in Anxiety Tolerance

BPD References:

Chatham (1985, p. 292) says: "With borderline personality, intense anxiety is often related to separations from significant others and loss of evocative memory of the good object."

BPD individuals characteristically "have difficulty managing anxiety and any increase in stress may be experienced as disorganizing or overwhelming. . . . Often borderline individuals experience panic reactions

dealing with separations from the therapist and significant others" (Goldstein, 1990, p. 43).

Masterson (1988, p. 112) says:

> Anxiety is present because borderline and narcissistic personalities cannot relate on a realistic level without giving up the defenses of the false self, which in turn make them feel exposed and vulnerable to the anxiety and depression that they are struggling hardest to avoid.

CODC References:

Cermak (1986a, p. 19) says that when the distance between the co-dependent and another person changes, the co-dependent may display intense BPD characteristics. The anxiety that is created by changing interpersonal distance can spiral into fear of abandonment or the fear of being overwhelmed by intimacy. These factors contribute to relationships being especially problematic for co-dependents.

Brown (1988, pp. 97-102) notes that lack of rules is a problem for her patients; it is related to a feeling of vulnerability. Their anxiety increases in direct proportion to the lack of structure in their lives. One said, "If I can just figure out what is required here I can behave accordingly and make the appropriate response." She says it is often their attempt to step out of their secure isolation that triggers their anxiety: "As soon as I picked a healthy partner, I lost all my confidence and began to have anxiety

attacks." In her work with ACOAs she finds that "attachment to key parental figures is based on maintaining the cognitive distortions and therefore the vulnerability and anxiety."

Problems in Affect Regulation

Affect Regulation

BPD References:

"Among the features that distinguish them from their less severe personality covariants is the dysregulation of their affects, seen most clearly in the instability and lability of their moods" (Millon, 1990, p. 127).

Goldstein observes that

> they lack continuity and sameness in the ways they present or experience themselves over time. These changes do not seem to be dependent on external events. Borderlines act differently even in similar circumstances. Each self-presentation is genuine but represents only one facet of the person, who may, seemingly without reason, demonstrate abrupt and radical shifts in feelings, attitudes, and behavior within hours, days, or weeks. Borderlines tend to perceive and experience others as changing even when they are remaining constant. They do not recognize that others remain the same and it is they who change. (Goldstein, 1984, quoted in Goldstein, 1990, p. 31)

CODC References:

Beattie (1987, pp. 42, 44-45) says co-dependents "don't say what they mean, don't mean what they say, don't know what they mean"; they vacillate in decisions and emotions.

Inability to Play

BPD References:

BPD patients have a deep-seated sense of guilt that does not permit them to enjoy life (Goldstein, 1990, p. 49). They were found "wanting in creative enjoyment, although not necessarily in sensual gratification" (Perry & Klerman, 1980, p. 168).

CODC References:

Beattie (1987, pp. 38, 44) says co-dependents "feel guilty about spending money on themselves or doing unnecessary or fun things for themselves" and they "find it difficult to have fun and be spontaneous." Woititz (1985, p. 89) agrees and adds that they take themselves very seriously.

Negative Affects

Anger

BPD References:

E. G. Goldstein (1990, pp. 44, 46-47) says that borderlines

> will go to any lengths to avoid directly acknowledging or revealing their anger or other thoughts, feelings and behaviors that they fear will lead to the destruction of the 'good' object and, thus, to abandonment. At the same time, they may act out their feelings. For example, while a patient who misses sessions or who attempts to leave treatment suddenly and prematurely may be expressing anger, these behaviors may serve to

> protect them and others from their aggression. If they do not see or confront the person with whom they are angry, or if they do not share the 'bad' parts of themselves, they preserve (through splitting) the 'good' object and 'good' self.

Gunderson and Singer (1975, p. 3) say that "anger seems to constitute the main or only affect that the borderline patient experiences" and that "the expression of this anger--or the defenses against it--are a major discriminating feature used to identify four separate subgroups of borderline patients."

Masterson (1988, p. 79) says the BPD client is unable to maintain consistent commitment in relationships when angry or frustrated, and he has difficulty evoking the image of loved ones when they are not physically present. The "borderline becomes a kind of 'fair weather' lover whose emotional investment in the partner will wane in times of disagreement or when tempers flare" (Masterson, 1988, p. 112).

CODC References:

Brown (1988, pp. 121-125) says that "anger is often the focal point around which issues of control, feelings, and the all-or-none frame are crystallized." To many ACOAs it is dangerous because they are afraid that feeling and expressing it will destroy the people they need to rely on and believe they must control. And most of all, she says, "anger threatens to repudiate denial of one's own

overwhelming deep neediness."

Weiss and Weiss (1989, p. 136) note that sometimes clients will repress angry feelings because they are so intense the clients are afraid that if they allowed themselves to feel they would destroy something or kill someone.

Wegscheider-Cruse (1987, p. 41) finds that co-dependents tend to intellectualize anger, examining every possible perspective as a way to avoid feeling their anger. She says they will disguise their anger, hinting at how they feel while smiling through clenched teeth. They are afraid that being angry will make them unlovable.

Beattie (1987, pp. 38, 43-44) says co-dependents "feel angry, victimized, unappreciated, and used"; they "feel very scared, hurt and angry" but have been shamed for feeling angry and now repress their angry feelings; they are afraid of their own and other people's anger; they "think other people make them feel angry" and they "feel controlled by other people's anger."

Problems in Self-Soothing

BPD References:

Goldstein (1990, p. 45) says: "Adler argues that this core deficit is more central to the borderline's problems than splitting." Adler believes that problems with

self-soothing and the need-fear dilemma largely account for the borderline's stormy interpersonal relationships. She states that Adler (1985) found that difficulty in self-soothing "is thought to result from their inability to evoke the image of a sustaining, holding, or soothing caretaker." It comes from failure to internalize enough positive experiences; the patient has nothing but negative introjects to draw on in times of stress and becomes overwhelmed by feelings of aloneness, panic, rage, and fear of abandonment (Goldstein, 1990, p. 45; Masterson, 1988, p. 44). Common examples are clinging behavior: Frequent phone calls to the therapist, requests for personal information, efforts to prolong the sessions, and agony when the therapist is on vacation.

CODC References:

Beattie (1987, 38-39) says co-dependents "believe other people couldn't possibly like and love them"; they "think they're not quite good enough" and "try to prove that they're good enough for other people."

Fears of Abandonment

Introduction

BPD References:

"A core problem for most borderline individuals is their need-fear dilemma that makes them ward off or withdraw

from the very positive experiences with others for which they long" (Goldstein, 1990, p. 46).

"In relationships, the person will either cling or stay aloof and emotionally uninvolved out of fear of being hurt or rejected" (Masterson, 1988, p. 77).

CODC References:

Woititz (1985, pp. 26-30) says fear of abandonment is "very strong" in ACOAs. She says abandonment differs from rejection, which she says they can handle. But they believe that "if you find out that I am not perfect, you will abandon me."

Beattie (1987, pp. 38, 41) says co-dependents "fear rejection" and "feel terribly threatened by the loss of any thing or person they think provides their happiness."

Woititz (1985, pp. 27-28) finds they constantly fear that the person they love will not be there for them tomorrow. She finds that

> whenever anything goes wrong (and in life, things go wrong), and when there is conflict (and in life, there is conflict), the fear of being abandoned takes precedence over dealing with the pertinent issue which needs to be resolved. This fear is so great that it is not unusual for COAs to completely lose sight of the actual problem.

Distancing

BPD References:

"The distancing defense can be crucial for a borderline's success at work or school" (Masterson, 1988, p. 119).

E. G. Goldstein (1990, p. 46) says that "the borderline's distancing maneuvers rarely work as a protection for very long, and they approach or try to merge once again. This oscillating cycle of clinging and distancing behavior is common to many borderline individuals."

CODC References:

Vannicelli (1989, pp. 154-159) relates how a patient projected his own need for distance on her by complaining of the seating arrangement in her office, even though he had voluntarily taken the seat that was farthest away from her in the room. He claimed the chair closer to her had never been there before though it had been in the same place for several years. The next week he sat in it briefly and then moved because he said the more distant chair, which was identical to it, was "more comfortable."

Rollercoastering

BPD References:

The process of cycling back and forth between clinging and distancing, which I call "rollercoastering," Melges and Swartz (1989, pp. 1115-1116) refer to as "oscillations of attachment." They explain that "problems with emotional attachment, such as overcompliance alternating with angry rebellion or idealization switching to devaluation of others, are common" in BPD empirical studies.

Masterson (1988, p. 119) says that

> when a close relationship materializes, it activates their real selves, which lack the capacities to make the relationship work. They give up their distancing defense, but unable to participate in a relationship without some form of protection, they resort to clinging dependency which, in effect, is a form of helplessness.

CODC References:

Cermak (1986a) commented on the similarity between CODC and BPD. When the distance between the co-dependent and another person changes, he says the co-dependent may display intense BPD characteristics. He says there may be rapid swings when one sees one's partner as all good or all bad. The co-dependent lurches back and forth between feeling totally inadequate and feeling in control. As black-and-white thinking increases, Cermak says the

co-dependent's world is split into friends and enemies. Friends are the people who support the co-dependent's denial. They commiserate with their pain; those friends often are idealized. Enemies are the people who insist on speaking the truth; they may become the target of intense rage.

The anxiety that is created by changing interpersonal distance can spiral into fear of abandonment or the fear of being overwhelmed by intimacy; according to Cermak, these factors contribute to relationships being especially problematic for co-dependents (Cermak, 1986a, p. 19).

Woititz (1985, pp. 23-24) says:

> You are torn apart by push-pull issues which may be illusionary to others, but are very real, and sometimes paralyzing, to you. 'I want to become involved--I don't want to become involved.' 'I want to meet someone--I don't want to meet someone.' 'I want to get to know you better. Please, simply go away.'

Problems in Self-Esteem Regulation

Self-Esteem Regulation

BPD References:

According to E. G. Goldstein (1990, p. 48), borderline patients have "either highly grandiose or devalued conceptions of their abilities and talents." They either feel entitled to special treatment or they feel unworthy. Their self-regard is not realistically based.

Their vulnerable self-regard may undergo radical change in response to the degree and nature of feedback received from other people; it may also be contingent on their ability to live up to their own perfectionistic standards.

Many BPD individuals are very sensitive to anything they perceive as criticism, disapproval, insensitivity, or lack of appreciation. "Seemingly minor events such as an unsolicited or unempathic therapeutic comment" may cause them to lash out at others in narcissistic rage, or indulge in fits of self-loathing (Goldstein, 1990, p. 49).

CODC References:

Mellody (1989, p. 7) describes the difficulty in experiencing appropriate levels of self-esteem as the number 1 core symptom of the co-dependent. She says co-dependents occupy both of the extremes; either they are arrogant and grandiose or they think they are worthless.

Co-dependents have unrealistic expectations of themselves and of others; they expect perfection yet feel they cannot do anything right. They are afraid of making mistakes. They have difficulty accepting criticism or praise. They are rigid and judgmental. They are critical of themselves and others (Beattie, 1987, pp. 38-39, 1989).

Woititz (1985, p. 40) says of co-dependents: "You do not want the person with whom you are involved to find

out how worthless and inadequate you are."

Superego Defects

BPD References:

BPD clients exhibit an absence of (appropriate) guilt and empathy in their relations with others and they are capable of performing ruthless and exploitative acts (Goldstein, 1990, p. 49). She said they may have a strict moral and ethical code but episodically engage in impulsive behavior that does not bother them.

Chatham (1985, p. 100) describes spotty elements in the superego integration of a patient she calls Sarah: "She felt only minimal guilt about her several extramarital affairs. In addition, she could feel devastated by criticism."

CODC References:

Woititz (1985, pp. 98-99) cautions that impulsivity is one of the ACOAs biggest enemies. The tendency to lock themselves into a course of action without thinking about alternative behaviors or possible consequences leads to loss of control over one's life. Co-dependents often feel anger as they struggle to clean up messy situations or lie their way out of them.

Co-dependents have difficulty accepting criticism or praise. They are rigid and judgmental. They are critical

of themselves and others (Beattie, 1987, pp. 38-39, 1989).

Intense and Unstable Interpersonal Relationships

Introduction

BPD References:

E. G. Goldstein (1990, pp. 49-50) believes that all of the characteristics that have been discussed thus far result from the borderline individual's pattern of intense and unstable personal relationships.

Intimacy

Goldstein observes that

> intimacy is a problem since the borderline tends to merge with or distance from others, or regulates closeness so it is not threatening. Closeness that is attained is rarely peaceful or lasting. Moodiness, possessiveness, insecurity, and highly charged interactions are common. Fights and accusations frequently occur and are usually related to feelings of being rejected or abandoned. (Goldstein, 1990, p. 50)

CODC References:

The anxiety that is created by changing interpersonal distance can spiral into fear of abandonment or the fear of being overwhelmed by intimacy. According to Cermak, these factors contribute to relationships being especially problematic for co-dependents (Cermak, 1986a, p. 19).

Janet Woititz wrote a best-selling book, *Struggle*

for Intimacy, on the ACOA's problems with intimacy. She deals with all of the other issues as subsidiary to this one, and related to it (Woititz, 1985).

The following is another example of the defense against intimacy that I call "rollercoastering"; it also relates to the fear of abandonment. Woititz (1985, pp. 23-24) describes the co-dependent person's ambivalence:

> You are torn apart by push-pull issues which may be illusionary to others, but are very real, and sometimes paralyzing, to you. 'I want to become involved--I don't want to become involved.' 'I want to meet someone--I don't want to meet someone.' 'I want to get to know you better. Please, simply go away.'

Summary

Based on this evidence, I conclude that these parallel passages show a remarkable similarity between BPD and CODC.

I think this "overlapped" population has been overlooked for several reasons. The first is that during their schooling clinicians appear to have been taught just the DSM criteria for BPD that were current when they were in school. They were not told of the underlying disagreements between researchers and clinicians on what BPD is, or that there exist other characteristics that may be more definitive and appropriate to make the diagnosis. Related to that lack of fundamental knowledge is the failure of many clinicians to recognize the significance of the change of

emphasis of the BPD criteria in DSM-IV, especially those characteristics in what has only recently come to be known as the identity cluster within the BPD category. These shortcomings would result in the failure to identify high-functioning clients as borderline at all, much less to put them in the identity cluster.

In addition, the results from the client survey and the results of the comparison of CODC and BPD literature reinforce each other. For example, the CODC clients scored highest on items in the following categories as identified by Conte et al. (1980): Emptiness or Sadness (78.5%), Impairment in Object Relations (70.5%), and Disturbances of Identity (66%,) with the percentage figure being the percentage of clients who endorsed the items in that category. In chapter 7 I review what some of the leading BPD theoreticians said about the importance of those categories in making the diagnosis of BPD. It is interesting to me that all three of these also come under the two categories that Goldstein (1990) places first and second in her listing, Identity Disturbances and Splitting and Other Related Defenses. She did not comment on the order in which she organized the categories but my examination of her list led me to conclude that she placed the items in order of importance. If that is true, then the results of the client survey are consistent with her assessment of the most important categories. When I checked

this out with her by telephone on April 22, 1996, she said:

> The characteristics are not necessarily in order of importance, you know, although I think in my mind I probably put them in order in terms of what I thought was most important but it was really more of a preconscious or unconscious process rather than a conscious one. It's interesting, as you say, that the characteristics are overlapping, although not surprising. (personal communication, April 22, 1996)

Therefore, one practical application of chapter 6 would be to use it as a reference to see what CODC authors as well as BPD authors have said about the three categories on which the CODC clients scored highest in the client survey.

Because the full quotations in these categories are available above, generally I quote only brief segments in the following sections.

1. Emptiness or sadness (78.5%). On the client survey portion of my research, 78.5% of the co-dependent persons endorsed the items in the emptiness category. In Goldstein's categories this is one of the six subgroups under Identity Disturbance and is thus closely related to the third topic that we examine, which Conte et al. (1980) refer to as Disturbances of Identity. Here is what experts in BPD and CODC said about emptiness. According to Gunderson and Kolb (1978, p. 795), "Loneliness and emptiness were very frequent complaints and quite specific to the borderline patients." Gunderson et al. (1991, p. 346) found that "emptiness is highly discriminating for the BPD

diagnosis ($p < .001$) whereas boredom is not."

Brown (1988, p. 109) refers to the co-dependents' pathological clinging to all-or-none thinking to cover the painful recognition of their isolation and aching loneliness.

Since the clients who endorsed the Borderline Syndrome Index items had been identified as co-dependent persons, and experts in CODC and BPD both identify emptiness as indicative of their respective diagnoses, this appears to be a good crosscheck of the results.

2. Impairment in Object Relations (70.5%). On the client survey portion of my research, 70.5% of the co-dependent persons endorsed the items in the Impairment in Object Relations category. In Goldstein's categories this comes under the general topic of Splitting and Other Related Defenses, which contains the following nine subgroups: Ambivalence, Assumption of Sameness, Communication Problems, Control, Denial and Dishonesty, Feelings, Gullibility, Idealization and Manipulation. Since the list is rather extensive, I mention only a few that are not covered in chapter 7.

Splitting refers to the way a person who did not achieve object constancy as a child will continue to relate to people as parts, even after he becomes an adult. In this context an object is a person and a part is a part of a

person (e.g., the good mother who feeds him or the bad mother who punishes him). Object constancy is the ability to recognize the good and bad in the same person, whether oneself or another. The person who has not achieved object constancy sees people as parts that are positive or negative, not as a whole entity consisting of both positive and negative. His world consists of friends or foes, blacks or whites, no middle ground. Masterson (1988, pp. 78-79) says such a person will be unable to maintain consistent commitment in relationships when he is frustrated or angry.

Co-dependents have conflicting views of themselves and others. Beattie (1987, pp. 42, 44-45) says they "don't say what they mean, don't mean what they say, don't know what they mean"; they combine passive and aggressive responses, they laugh when they feel like crying, they vacillate in decisions and emotions, they are both responsible and irresponsible.

Generally unconcerned about the blatant contradictions in the ways they experience themselves, borderline individuals do not worry about or try to resolve these discrepancies. They rationalize them or become angry or defensive if these are pointed out (Goldstein, 1990, p. 36).

Under the subgroup of Control, Goldstein mentions the "omnipotent control, in which a person with a highly

inflated sense of self attempts to control others totally" (Goldstein, 1990, p. 36). Masterson (1988, p. 126) describes a client for whom control, fear, and fantasy were the central themes of life.

Brown (1988, p. 115) says,

> In all of our work, we have been amazed at the repeated emphasis on control, identified as a problem in its own right, and as a structure for interpreting self and other. In examining difficulties related to establishing and maintaining intimate relationships, the need for "control" and the impact of control as a structure are central.

Schaef (1986, pp. 56-7) says that as their life situation becomes more chaotic, the co-dependent tries to exert more and more control.

Another very important item in this category is Denial and Dishonesty. Goldstein (1990, p. 39) warns that therapists should be alert to what clients may not share as well as what they reveal in treatment. She says they tend to keep important and possibly very troublesome issues out of their treatment sessions.

Vannicelli (1989, pp. 142-146) says co-dependents tend to edit or withhold certain information from anyone they want to impress, even their therapist.

3. Disturbances of Identity (66%). On the client survey portion of my research, 66% of the co-dependent persons endorsed the items in the Disturbances of Identity category. In Goldstein's book she calls this section

Identity Disturbances and she puts it in first place. We have already dealt with one of the subgroups in this category, Emptiness (Loneliness). Other subgroups are: External Referenting, Identity Diffusion, Intellectualizing, Perfectionism, and Sexual Problems.

With regard to external referenting, Goldstein (1990, p. 31) says: "Some borderline individuals literally take on the identities of certain others with whom they associate. They define themselves in terms of how others see them."

Schaef (1986, pp. 44-52) places external referenting first on her list of CODC characteristics. She says co-dependents feel they have no intrinsic worth. They derive their meaning from other people; they are externally referented and will do almost anything to be in a relationship. . . . They ask themselves "What will other people think?"

With regard to Identity Diffusion, Kernberg et al. (1989, p. 5) said identity diffusion is the lack of integration of the concept of the self or of significant others and is evidenced in the patient's experience of chronic emptiness, contradictory self-perceptions and behavior, and impoverished and contradictory perceptions of other people, and the difficulty the patient has in communicating their significant interactions with others to

their therapist.

Brown (1988, p. 181) says ACOAs "cannot negotiate emotional separation because they lack an adequate base of attachment from which maturation and separation can occur."

On Intellectualizing, Masterson (1988, p. 87) said:

> They [BPDs] may use a high IQ and a tendency to intellectualize to enter a profession. . . . Any career such as reporter, photographer, psychiatrist, or minister which requires professional detachment places one in a position to project oneself into others' lives and identify with life dramas being played out there without fully committing oneself to the same emotions and activities in one's own life.

Wegscheider-Cruse (1987, p. 41) says intellectualizing is a basic defense of co-dependents.

On Perfectionism, Goldstein (1990, pp. 41-42) says borderline individuals may protect an idealized and perfectionist self-image through denial and/or splitting off of angry or other unacceptable feelings that sometimes break out, without warning, under circumstances that shatter their fragile self-concept or self-cohesion.

Beattie (1987, p. 38) notes that co-dependents "expect themselves to do everything perfectly." Larsen (1985, p. 24) says: "Not only must the 'things' around them be perfect, but so must the people. They are absolute masters at finding fault."

Finally, regarding Sexual Problems, confusion regarding sexual orientation or sexual preference was mentioned as a common source of concern or anxiety for BPD

patients (Goldstein, 1990; Masterson, 1988). Head (1991) found that impulsive sexual behavior may be one kind of impulsiveness that is specific to borderlines.

Woititz (1985, pp. 59-70) devotes an entire chapter to sexual issues, starting with confusion about one's sexual identity and sexual orientation, presenting those as serious problems for co-dependents.

Several authors mentioned the increasing awareness of childhood sexual abuse as an important issue in BPD (Herman et al., 1989; Winchel & Stanley, 1991, p. 309).

Janet Woititz says that a history of incest is not uncommon in co-dependents (Woititz, 1985, pp. 66-69).

The parallel passages depicted in this chapter show a remarkable similarity between BPD and CODC. To confirm and supplement this, the results of the client survey that is reported in chapter 7 show that the three categories in which the clients scored highest all come under the categories that Goldstein (1990) places first and second in her listing, Identity Disturbances, and Splitting and Other Related Defenses. Thus, it appears that the documentary evidence in this chapter and the results of the client survey are consistent.

CHAPTER 7

DATA ANALYSIS

Clinician Survey

The material in this section provides part of the answer to Research Question #2: If there is some overlap of CODC and BPD, is the overlap recognized by practicing clinicians? The purpose of this survey was to determine what clinicians thought about BPD and CODC. Specifically, the form directed clinicians to "Please check the items below that you believe are characteristic of BPD, COD, or both." I wanted to know whether *they believed* any or all of the 10 items on the survey were among the criteria for BPD, for CODC, for both BPD and CODC, or for neither of them. The 10 items were taken directly from the BPD literature and were quotations that one or more respected authorities on BPD consider to be diagnostic of BPD. Therefore a respondent who indicated that an item referred to CODC was automatically relating CODC to a descriptor of BPD.

A total of 138 Anonymous Survey responses were received from clinicians, with 101 of them coming from the November 1995 Annual Meeting of the Kentucky Psychological

Association (KPA.) KPA provided a table for me in the registration area for the purpose of collecting these data.

In the total of 138, there were 83 doctoral-level (Ph.D., Psy.D., and Ed.D.) respondents, 41 respondents with master's degrees in psychology, 8 respondents with M.S.W.s, and 6 respondents who had degrees such as R.N. and B.A.

The first question on the survey asked: "Do you ever diagnose a client as 'Borderline Personality Disorder' (BPD)? __Yes __No." Of the clinicians who responded, 100% of those with M.S.W. degrees, 93% of the doctoral level clinicians, and 90% of those with master's degrees in psychology said "yes," indicating that there is widespread use of the BPD diagnosis, as Table 1 illustrates.

TABLE 1

ANONYMOUS SURVEY RESULTS: DO YOU EVER DIAGNOSE BPD? (N = 138)

Clinician	Yes	%	No	%
Doctoral level (N = 83)	77	93	6	7
Master's in Psych. (N = 41)	37	90	4	10
M.S.W. degree (N = 8)	8	100	0	0
Other degrees (N = 6)	3	50	3	50

Since CODC is not an actual diagnosis, instead of asking if clinicians "diagnosed" CODC, the second question asked "Do you ever treat clients for 'co-dependency' (CODC)? __Yes __No." Compared to the number of clinicians who said they diagnosed clients as BPD, fewer of the master's- and doctoral-level psychologists said they treated CODC. Only 61% of the doctoral-level clinicians said they treated CODC whereas 93% had said they treated BPD. Similarly, 66% of the master's-level psychologists said they treated CODC whereas 90% had said they treated BPD. A full 100% of master's-level social workers said they treated CODC and 100% had said they treated BPD. (See Table 2.)

TABLE 2

ANONYMOUS SURVEY RESULTS: DO YOU EVER TREAT CLIENTS FOR CODC? (*N* = 138)

Clinician	Yes	%	No	%	No response
Doctoral level (*N* = 83)	51	61	31	37	1
Master's in Psych. (*N* = 41)	27	66	14	34	
M.S.W. degree (*N* = 8)	8	100	0	0	
Other degrees (*N* = 6)	1	17	5	83	

The third question asked "Do you think codependence should be a DSM diagnostic category? __Yes __No." Although 61% of doctoral-level psychologists had said they treated CODC, only 15% thought it should be a diagnostic category. Similarly, only 42% of master's level psychologists thought it should be a diagnostic category, although 66% of them had said they treated it. An even bigger surprise was that only 50% of the master's-level social workers thought it should be in DSM even though 100% of them had said they treated it (see Table 3).

TABLE 3

ANONYMOUS SURVEY RESULTS: SHOULD CODC BE A DSM CATEGORY? (*N* = 138)

Clinician	Yes	%	No	%	No response
Doctoral level (*N* = 83)	12	15	68	82	3
Masters in Psych. (*N* = 41)	17	42	19	46	5
M.S.W. degree (*N* = 8)	4	50	4	50	
Other degrees (*N* = 6)	2	33	4	67	

Please note that I use the term master's-level

"psychologist" to differentiate them from social workers and do not mean to imply that all of them are licensed and eligible to use some form of the word psychology in their professional designation, such as Psychological Associate in Kentucky or Psychological Examiner in Tennessee. Also, several of the individuals with "other" degrees indicated limitations such as the fact that they did not themselves diagnose or treat clients.

The main body of the instrument listed 10 characteristics and asked if the clinician thought each of the items was a characteristic of BPD, of CODC, or of both. Table 4 shows the number and percentage of respondents who believed each of the 10 items are among the characteristics of CODC, and the number and percentage of those who did not. The mean response for those who believed the items were characteristics of CODC was 46.7%.

Table 5 shows the number and percentage of respondents who believed each of the 10 items are among the characteristics of BPD, and the number and percentage of those who did not. The mean response for those who believed the items were characteristics of BPD was only 69.6%.

The "yes" responses from Tables 4 and 5 are shown side by side in Table 6. Looking at all the characteristics as a whole, 69.6% of all the items were identified as BPD and 46.7% of those same items were identified as CODC.

On Questions #1, #3, #5, #6, #7, and #8 the

TABLE 4

ANONYMOUS SURVEY RESULTS: DO RESPONDENTS BELIEVE THE ITEMS ARE CHARACTERISTIC OF CODC? (*N* = 138)

Question	Yes	%	No	%
#1	80	58	58	42
#2	105	76	33	24
#3	79	57	59	43
#4	72	52	66	48
#5	38	27	100	73
#6	56	40	82	60
#7	23	17	115	83
#8	71	51	67	49
#9	72	52	66	48
#10	51	37	87	63

TABLE 5

ANONYMOUS SURVEY RESULTS: DO RESPONDENTS BELIEVE THE ITEMS ARE CHARACTERISTIC OF BPD? (*N* = 138)

Question	Yes	%	No	%
#1	115	83	23	17
#2	33	24	105	76
#3	123	89	15	11
#4	82	59	56	41
#5	129	93	9	7
#6	109	79	29	21
#7	128	93	10	7
#8	111	80	27	20
#9	52	38	86	62
#10	80	58	58	42

TABLE 6

ANONYMOUS SURVEY RESULTS: A COMPARISON OF THE YES RESPONSES FOR BPD AND CODC (*N* = 138)

Question	CODC	%	BPD	%
#1	80	58	115	83
#2	105	76	33	24
#3	79	57	123	89
#4	72	52	82	59
#5	38	27	129	93
#6	56	40	109	79
#7	23	17	128	93
#8	71	51	111	80
#9	72	52	52	38
#10	51	37	80	58

percentages were 79 or more, with #5 and #7 each being 93%.

It is enlightening also to isolate responses to the five identity cluster questions, #5, #6, #8, #9, and #10. See Table 7 for the responses on these items for CODC and Table 8 for the responses to BPD. The mean affirmative response for CODC was 41.4%, slightly less than the mean for all the items, and for BPD the mean affirmative response was only 69.6%, the same as for all of the BPD items together.

Table 9 combines the "yes" responses from Tables 7 and 8. Table 9 shows the extent to which people with characteristics in the identity cluster were considered by respondents to this survey to be co-dependent or BPD. Since the identity cluster has been given more emphasis in DSM-IV, these types of questions are very important.

The fact that only 69.6% of the items were identified as characteristics of BPD is disappointing, but was expected. Only 3 of the 5 items were correctly identified by 80% or more of the clinicians. This indicates a lack of information on the current diagnostic criteria as distinct from the criteria in previous editions of the DSM. This is shown in Table 10. Out of the 138 clinicians in the survey only 23, or 17%, recognized all five identity cluster questions as diagnostic of BPD. Only 12 of these were doctoral-level clinicians, or 14% of all doctoral-level clinicians in the survey. Both groups of master's-level clinicians did slightly better, with 22% each.

TABLE 7

ANONYMOUS SURVEY RESULTS: RESPONSES TO IDENTITY CLUSTER QUESTIONS FOR CODC (N = 138)

Question	Yes	%	No	%
#5	38	27	100	73
#6	56	40	82	60
#8	71	51	67	49
#9	72	52	66	48
#10	51	37	87	63

TABLE 8

ANONYMOUS SURVEY RESULTS: RESPONSES TO IDENTITY CLUSTER QUESTIONS FOR BPD (N = 138)

Question	Yes	%	No	%
#5	129	93	9	7
#6	109	79	29	21
#8	111	80	27	20
#9	52	38	86	62
#10	80	58	58	42

TABLE 9

ANONYMOUS SURVEY RESULTS: A COMPARISON OF THE YES RESPONSES TO THE IDENTITY CLUSTER QUESTIONS FOR BPD AND CODC (*N* = 138)

Question	CODC	%	BPD	%
#5	38	27	129	93
#6	56	40	109	79
#8	71	51	111	80
#9	72	52	52	38
#10	51	37	80	58

TABLE 10

ANONYMOUS SURVEY RESULTS: A COMPARISON OF YES RESPONSES TO ALL OF THE IDENTITY CLUSTER QUESTIONS FOR BPD AND CODC, BY CLINICIAN TYPE (*N* = 138)

Question	BPD	%	CODC	%
Total yes responses	*N* = 23	17	*N* = 6	4
Doctoral level	*N* = 12	14	*N* = 3	4
Psych. Master's	*N* = 9	22	*N* = 3	7
M.S.W.	*N* = 2	22	*N* = 0	0

Note. "Other" was not computed.

Client Survey

The material in this section provides the answer to Research Question #3: How would co-dependent persons score on a BPD test instrument?

The purpose of this survey was to determine how co-dependent persons perceive and describe the way they feel and act. Since there are no diagnostic criteria for CODC, I used the same criteria that are used in general society: Co-dependents were defined as persons who were raised or now live in an alcoholic family, who describe themselves as co-dependent, or who are considered to be co-dependent by another person such as a relative, friend, or counselor.

Borderline Syndrome Index

Because I am interested in finding out whether persons who are considered co-dependent have the same characteristics as persons diagnosed as having BPD, I chose to use the Borderline Syndrome Index (BSI) as the instrument for this research. For the purposes of this dissertation the principal author of the BSI, Dr. Hope R. Conte, granted permission for me to use the instrument under a different name, Anonymous Personality Style Inventory (APSI.)

Permission was granted to distribute the APSI to clients in clinical settings and to persons who volunteered to complete the form at support groups such as Al-Anon when an individual was willing to take on the responsibility of

handing out the forms and mailing the completed ones to me. The clinical settings utilized were the family program in the substance abuse treatment facility of a major regional hospital in Corbin, Kentucky, and two community mental health centers, in Hazard and Jackson, Kentucky.

As in the 1980 study, the survey forms were offered to members of the target population; in this case, CODC. There are no diagnostic criteria for CODC. The criteria used for this study were the same as the "criteria" for attendance at a CODC support group such as Al-Anon, namely identification with the group. The persons who completed the APSI did so voluntarily. They identified themselves as co-dependent or stated that they have been told they are co-dependent by someone else such as a relative, friend, or counselor, even though they may not agree with that opinion. Usually people describe themselves as co-dependent because of living in or coming from an alcoholic or other substance-abusing family (Wegscheider-Cruse, 1984).

To review the reliability data discussed in chapter 5, the reliability of the BSI, as determined by the Kuder-Richardson Formula 20, was .92, which indicates high internal consistency (Conte et al., 1980).

Post hoc comparisons (Scheffe) showed the borderline group's mean score of 26.31 (SD = 8.27) was significantly higher than the mean score of 5.92 (SD = 5.5) for the normal group at better than the .001 level. Conte et al. (1980)

provided a percentile table of preliminary norms based on data obtained from 35 borderline and 36 depressed outpatients, 20 schizophrenic inpatients, and 50 normal subjects (see Appendix E). Based on those figures, in this study a raw score of 16 is used as the cutoff score to distinguish normal subjects from those who endorsed an unusually high number of BPD characteristics. In this study a score of 25 or more is considered indicative of BPD traits. In the 1980 study, "approximately half of the borderline patients obtained a raw score of 25 or less," yet "almost 100% of the normal subjects obtained such a score" (Conte et al., 1980, p. 433).

The results of this survey indicate a very close relationship between persons who are co-dependent and persons who are diagnosed as having BPD. As you can see in Table 11, of the 44 people who completed the survey, 12 had scores of 16 or less, placing them in the normal category. There were 8 individuals with scores of more than 16 but fewer than 25. To be conservative, they were not considered part of either the normal or BPD group.

Of particular interest for this study, there were 24 individuals who had scores of 25 or more which, according to the 1980 study, "would provide supportive evidence for a diagnosis of borderline" (Conte et al., 1980, p. 434). Indeed, in this study there were 17 scores of 36 or more and 9 of those were 40 or more; these compare with scores

TABLE 11

APSI AND DISCRIMINATING ITEMS SCORES (N = 44)

APSI Scores		Discriminating Items
0	-	0
0	-	0
1	-	1
5	-	2
5	-	3
10	-	1
10	-	3
11	-	2
13	-	5
14	-	3
15	-	5
16	-	7
19	-	7
20	-	4
20	-	6
21	-	7
22	-	6
22	-	7
23	-	6
23	-	7
25	-	5
27	-	8
32	-	7
33	-	9
33	-	8
34	-	9
35	-	8
36	-	8
36	-	9
36	-	9
37	-	9
39	-	8
39	-	8
39	-	9
39	-	10
40	-	7
40	-	10
43	-	9
43	-	9
45	-	9
45	-	10
48	-	10
50	-	10
52	-	10

obtained in the original study by 90% and 95% of borderline individuals, respectively.

The mean of the CODC scores in this study is 27.18 (SD = 14.52) that is higher than the mean BPD score of 26.31 (SD = 8.27) in the 1980 study. The BPD mean of 26.31 was higher than the 1980 normals group mean of 5.92 (SD = 5.5) at better than the .001 level.

There were 39 items, or 75% of the 52 items on the BSI, on which the CODC group scored higher than the BPD group or within 5 points of them.

Discriminating Items

Table 11 shows also that only one person with a score over 25 endorsed fewer than 7 of the 10 discriminating items which the original study had found were "highly endorsed by the borderline patients or that showed a marked difference between borderline patients and other groups" (Conte et al., 1980, p. 431). Table 12 shows more clearly the distribution of scores on the discriminating items.

By counting the numbers in the horizontal rows of Table 12, we see that two individuals obtained scores of 0, of 1, and of 2 on the discriminating items. Similarly, three individuals obtained scores of 3, of 5, and of 6; one person obtained a score of 4; seven individuals obtained a score of 7; six persons obtained scores of 8 and of 10; and nine persons obtained a score of 9.

TABLE 12

DISTRIBUTION OF DISCRIMINATING ITEMS SCORES (N = 44)

0	0							
1	1							
2	2							
3	3	3						
4								
5	5	5						
6	6	6						
7	7	7	7	7	7	7		
8	8	8	8	8	8			
9	9	9	9	9	9	9	9	9
10	10	10	10	10	10			

Of the 44 people in this survey, 28 endorsed 7 or more of the discriminating items and 6 people endorsed all 10. The discriminating items fall into five general categories that correspond to the same characteristics I used to compare CODC and BPD in chapter 6. The categories and the items within them are shown in Table 13 (based on data in Conte et al., 1980, p. 431).

The five categories we are concerned with and the average of the CODC individuals scores on the two items in each category are: Emptiness or Sadness (78.5%), Impairment in Object Relations (70.5%), Disturbances of Identity (66%), Impulsivity (57.5%), and Poor Work History or what I call

TABLE 13

RAW AND PERCENTAGE SCORES ON DISCRIMINATING ITEMS, ARRANGED BY CATEGORY (N = 44)

Item #	Raw Score	%	Text of item
Disturbances of identity:			
1.	26	59	I never feel as if I belong.
52.	32	73	Sometimes I am not myself.
Impairment in Object Relations:			
4.	30	68	I am afraid to form a close personal relationship.
5.	32	73	People who seem great at first often turn out to disappoint me.
Poor Work History or Failure to Achieve Potential:			
21.	31	70	I never accomplish as much as I could.
34.	18	41	I am a failure.
Emptiness or Sadness:			
9.	34	77	I feel empty inside.
11.	35	80	I feel lonesome most of the time.
Impulsivity:			
25.	20	45	I can't tell what I will do next.
42.	31	70	It's hard for me just to sit still and relax.

Failure to Achieve Potential (55.5%.) Let us look again at what the BPD authorities say about these characteristics. They are depicted in Table 14. I discuss them in descending order, beginning with the one on which the CODC individuals scored highest. The scores are given first in bold face type; clinical interpretations follow in regular type.

In *Emptiness or Sadness* the CODC group scored 77% on "I feel empty inside," 8 points higher than the BPD score of 69% and 71 points higher than the normals score of 6%. The CODC group scored 80% on "I feel lonesome most of the time" or the same as the BPD score of 80% and 66 points higher than the normals score of 14%.

Emptiness or Sadness: According to Gunderson and Kolb (1978, p. 795), "Loneliness and emptiness were very frequent complaints and quite specific to the borderline patients." A later study (Gunderson et al., 1991, p. 346) showed that "emptiness is highly discriminating for the BPD diagnosis ($p < .001$) whereas boredom is not."

In *Impairment in Object Relations* the CODC group scored 68% on "I am afraid to form a close personal relationship," 8 points higher than the BPD score of 60% and 56 points higher than the normals score of 12%. The CODC group scored 73% on "People who seem great at first often turn out to disappoint me" or 4 points higher than the BPD score of 69% and 33 points higher than the normals' 40%.

TABLE 14

COMPARISON OF PERCENTAGE OF SCORES ON DISCRIMINATING ITEMS ON THE APSI (CODC) AND IN THE ORIGINAL BSI STUDY

Item	BPD (N = 35)	CODC (N = 44)	Normals (N = 50)
# 9	69	77	06
#11	80	80	14
# 4	60	68	12
# 5	69	73	40
# 1	69	59	08
#52	74	73	38
#25	54	45	10
#42	71	70	36
#21	86	70	46
#34	51	41	04

Impairment in Object Relations: Kernberg suggested that borderline patients' core difficulty lies in their inability to bring together and integrate loving and hating aspects of both their self-image and their image of another person. Kernberg's observation was that these patients cannot sustain a sense that they care for the person who frustrates them. Kernberg saw this characteristic failure in the achievement and tolerance of ambivalence and in the modification of affects as diagnostic of the borderline individual (Shapiro, 1978, p. 1307).

Melges and Swartz (1989, pp. 1115-1116) refer to "oscillations of attachment," explaining that "problems with emotional attachment, such as overcompliance alternating with angry rebellion or idealization switching to devaluation of others, are common" in BPD empirical studies. James Masterson explains:

> When a close relationship materializes, it activates their real selves, which lack the capacities to make the relationship work. They give up their distancing defense, but unable to participate in a relationship without some form of protection, they resort to clinging dependency which, in effect, is a form of helplessness. (Masterson, 1988, p. 119)

"In relationships, the person will either cling or stay aloof and emotionally uninvolved out of fear of being hurt or rejected" (Masterson, 1988, p. 77).

Like Kernberg, Goldstein also sees this as a basic problem for borderlines: "A core problem for most borderline individuals is their need-fear dilemma that makes them ward off or withdraw from the very positive experiences with others for which they long" (Goldstein, 1990, p. 46).

In *Disturbances of Identity* the CODC group scored 59% on "I never feel as if I belong," 10 points lower than the BPD score of 69% but 51 points higher than the normals score of 08%. The CODC group scored 73% on "Sometimes I am not myself" or 1 point lower than the BPD score of 74% but 35 points higher than the normals score of 38%.

Disturbances of Identity:

> Some borderline individuals literally take on the identities of certain others with whom they associate. They define themselves in terms of how others see them. Their interests, values, modes of dress, and mannerisms shift as the nature of their attachments change. (Goldstein, 1990, p. 31)

The self-concept of BPD individuals can be highly inflated (perfectionistic) or depreciated, or may alternate between them; "borderline individuals have difficulty acknowledging any characteristics, thoughts, or feelings that violate their particular views of themselves" (Goldstein, 1990, p. 31).

In *Impulsivity* the CODC group scored 45% on "I can't tell what I will do next," 9 points lower than the BPD score of 54% but 35 points higher than the normals score of 10%. The CODC group scored 70% on "It's hard for me just to sit still and relax" or 1 point lower than the BPD score of 71% but 34 points higher than the normals score of 36%.

Impulsivity: The borderline's impulsiveness is often a result of responding to his or her anger. Gunderson and Singer (1975, p. 3) said that *anger* and its defenses, such as *splitting,* are a "major discriminating feature" to identify four subgroups of BPD patients. E. G. Goldstein (1990, p. 41) writes:

> Borderline individuals' impulsiveness contributes substantially to the turbulent, unpredictable, and crisis-ridden nature of their lives. . . . Impulsive individuals who utilize splitting, and thereby come to view a friend, lover, or therapist who frustrates or

disappoints them as all 'bad,' may break off their relationships suddenly.

In *Poor Work History or Failure to Achieve Potential* the CODC group scored 70% on "I never accomplish as much as I could," 16 points lower than the BPD score of 86% but 24 points higher than the normals score of 46%. The CODC group scored 41% on "I am a failure" or 10 points lower than the BPD score of 51% but 37 points higher than the normals' 4%.

Poor Work History or Failure to Achieve Potential: The failure to succeed at work or achieve his or her potential in other areas is largely rooted in the BPD person's inability to get along with other people. BPD individuals oscillate between devaluing themselves and exhibiting a sense of entitlement, which leads to stormy interpersonal relationships at work as well as at home and in the community. According to E. G. Goldstein (1990, p. 48), borderline patients have "either highly grandiose or devalued conceptions of their abilities and talents." They either feel entitled to special treatment or they feel unworthy. Their self-regard is not realistically based. Their vulnerable self-regard may undergo radical change in response to the degree and nature of feedback received from other people; it may also be contingent on their ability to live up to their own perfectionistic standards.

Many BPD individuals are very sensitive to anything they perceive as criticism, disapproval, insensitivity, or

lack of appreciation. "Seemingly minor events such as an unsolicited or unempathic therapeutic comment" may cause them to lash out at others in narcissistic rage, or indulge in fits of self-loathing (Goldstein, 1990, p. 49).

The words of these borderline authorities regarding the discriminating items explain and reinforce the empirical evidence obtained by Conte and her colleagues regarding the importance of those items in making the BPD diagnosis. It seems clear that the CODC clients who endorsed so many of the discriminating items put themselves in the BPD category.

Conte et al., in Table 1, p. 432, 1980, show the percentage scores of the four groups in the original study. With Conte's permission, this table is reproduced in Appendix E.

To complete the listing of CODC scores I have computed the percentage of endorsement of all 52 of the items by the CODC group. In Appendix E, also with Dr. Conte's permission, I have included a new table using my CODC data and the data on BPD and Normals from Table 1 (Conte et al., 1980, p. 432) mentioned above. There are 39 items, or 75% of the 52 items on the BSI, on which the CODC group scored higher than the BPD group or within 5 points of them.

The evidence from the client survey is much stronger than I anticipated. I believe the prevalence and severity of sexual abuse in the area sampled may well account for the

unexpectedly high CODC scores.

Summary

I obtained evidence of the similarity of CODC and BPD by conducting surveys of clinicians and co-dependent persons. I created my own instrument to determine the clinician's knowledge of the characteristics of BPD. I obtained and analyzed 138 responses. The author gave me permission to distribute the 52-item Borderline Syndrome Index to co-dependent persons. I analyzed the 44 scores and compared them with the original 1980 scores of 50 normal persons and 35 persons diagnosed with BPD.

CHAPTER 8

CONCLUSION

Purpose of the Study

The purpose of this study was to determine whether Co-dependence (CODC) and Borderline Personality Disorder (BPD) are separate entities or whether their characteristics overlap as they are described in the pop-psychology and clinical literature respectively, and as they are perceived by clinicians and clients. This chapter provided an overview of the issue, defined key terms, said the study is important, stated three research questions and assumptions, gave the sources of data, and briefly outlined the study.

Review of CODC Literature

CODC was conceptualized in addictions treatment centers when certain characteristics were found in family members of the addicted persons, initially alcoholics. The meaning of the term "codependent" was later expanded to include the relatives and friends of persons with any addiction, not just alcoholism, and often the addicted person as well. Until recently, mainstream mental health

professionals were not involved with this population.

CODC was said to be a progressive lifelong disease that affects every member of the alcoholic's family and as much as 96% of the entire country. The role of Al-Anon and other Twelve Step support groups for ACOAs, co-dependents, and others was discussed. Several authors were quoted as saying that treating newly discovered and loosely defined addictive "diseases" in hospital-like settings, and the publication of pop-psychology self-help books, had become a billion dollar business.

Review of BPD Literature

One similarity between CODC and BPD is the amount of disagreement regarding definition and criteria among the experts in each field. Frances et al. (1984) refer to the "beguiling vagueness" of BPD, saying the concept has been used in so many ways it defies description. Clark (1995, p. 483) said the terminology used is "often ambiguous, confusing, or inconsistent" and notes that similar issues are discussed using different terminology or the same terms are applied in different ways. Examples include the following topics: The contrast between BPD outpatients who seek treatment voluntarily and BPD inpatients who are often referred for treatment by others; borderline personality organization; dimensional, categorical, prototypical, and ideal types diagnostic systems.

Review of CODC and BPD Similarities

I examined the phenomenon of CODC and noted how public awareness of the topic appears to have been fueled by skillful marketing of self-help books described by one critic as remarkable for their "sameness" and "earnest fatuity." I looked beyond the stereotypical borderline patient to higher functioning individuals with IQs one or two standard deviations above the mean. I noted that experts declined to include CODC as a diagnosis in the latest DSM and examined statements about the similarity of CODC and BPD written by two leading proponents of CODC, Bradshaw and Cermak. The similarity was confirmed in Hoover's doctoral dissertation. I suggested that if CODC and BPD are indeed similar, the outcome of treatment should be similar. The fact that BPD treatment appears to be more effective than treatment of CODC may be a reflection of inadequate training and credentialing of CODC counselors.

Methodology

I studied the construct of "co-dependence" to determine whether clinicians perceive it as fitting into the existing diagnostic category of borderline personality disorder. I obtained the primary documentary evidence by conducting archival research of the extensive pop-psychology literature on CODC and the equally extensive clinical literature on BPD. To present the findings I made a side-

by-side comparison of the two bodies of literature utilizing the characteristics of BPD identified by Eda G. Goldstein.

I obtained secondary supporting evidence of the similarity of CODC and BPD by conducting anonymous self-report surveys of clinicians and co-dependent persons. I created my own instrument for clinicians. The Anonymous Survey was designed to determine the clinician's knowledge of the characteristics of borderline personality disorder in general, and more specifically their knowledge of criteria for the identity cluster. I obtained and analyzed 138 responses.

I obtained permission from the author to distribute the 52-item self-report Borderline Syndrome Index to co-dependent persons, using the more innocuous title of the Anonymous Personality Style Inventory. I analyzed the scores obtained by 44 co-dependent persons and compared them with the original 1980 scores of 50 normal persons and 35 persons diagnosed with borderline personality disorder.

Characteristics Common to BPD and CODC

I classified the characteristics of CODC and BPD according to the following categories, which E. G. Goldstein (1990, pp. 30-52) used in chapter 3 of *Borderline Disorders: Clinical Models and Techniques* to describe the borderline personality: Identity Disturbances, Splitting and Other Related Defenses, Reality Testing and Psychotic-Like

Features, Problems in Impulse Control, Problems in Anxiety Tolerance, Problems in Affect Regulation, Negative Affects, Problems in Self-Soothing, Fears of Abandonment, Problems in Self-Cohesion, Problems in Self-Esteem Regulation, Superego Defects, Intense and Unstable Interpersonal Relationships.

The quotations in this chapter are more detailed than those in the previous two chapters. There are numerous additional quotations here that were not germane to the previous chapters but are relevant in this context. This chapter consists of a side-by-side presentation of descriptions by recognized authorities in the fields of CODC and BPD articulating the characteristics that one body of literature says is diagnostic of BPD and another body of literature says is "diagnostic" of CODC. These parallel passages show a consistent similarity between BPD and CODC.

Data Analysis

1. Clinician Survey. The Anonymous Survey of clinicians indicated a need for broader and deeper education of psychologists on the theoretical underpinnings of BPD. Psychologists have not kept up with the changes in the diagnostic criteria and the rationale for those changes. They seem to be unaware of the controversy over what BPD is and other criteria by which it *could* be diagnosed.

Although the text of all 10 of the items on the survey consisted of quotations from the clinical literature

on BPD, only 69.6% of the 10 characteristics all together, or the five items that comprise the identity cluster, were identified as being diagnostic of BPD.

Only 14% of the doctoral-level clinicians in the survey were able to identify all of the identity cluster items as being BPD.

2. Client Survey. The purpose of this survey was to determine how co-dependent persons perceive and describe the way they feel and act. Co-dependents were defined as persons who were raised or now live in an alcoholic family, who describe themselves as co-dependent, or who are considered to be co-dependent by another person such as a relative, friend, or counselor.

The Borderline Syndrome Index (Conte et al., 1980) with K-R 20 reliability of .92 was utilized for this research using the name Anonymous Personality Style Inventory (APSI). The APSI was offered to co-dependent client volunteers at the substance abuse treatment center of a regional hospital in Corbin, Kentucky, at mental health centers in Hazard and Jackson, Kentucky, that have dual diagnosis programs where substance abusers and co-dependents are treated, and an Al-Anon meeting.

On the 10 most discriminating items of the APSI, the co-dependent persons always scored higher than the normal group, and closer to the BPD group than to the normals. On 3 of the 10 discriminating items the CODC group scored

higher than the BPD group, on one they scored the same, and on two the CODC group was only 1 point below the BPD group. The CODC group scored higher than or within 5 percentage points of the BPD group on 39 or 75% of the 52 items of the complete instrument.

The clinical importance of these scores was discussed, particularly because two of the areas where the CODC group scored highest are areas that are highly indicative of BPD, *Emptiness or Sadness* and *Impairment in Object Relations.* The literature reviews showed that childhood sexual abuse has been associated with BPD and CODC. The prevalence of sexual abuse in eastern Kentucky may account for the unexpectedly high CODC scores.

Conclusions

Research question #1 asked: Is there an area of overlap between what pop-psychology calls CODC and the clinical literature calls BPD? Documentary evidence indicated an abundance of characteristics common to CODC and BPD.

Research question #2 asked: If there is some overlap of CODC and BPD, is the overlap recognized by practicing clinicians? The answer appears to be that during their schooling clinicians are taught just the DSM criteria for BPD that are current when they are in school. They are not told of the underlying disagreements between researchers

and clinicians on what BPD is, or that there exist other characteristics that may be more definitive and appropriate to make the diagnosis. Related to that lack of fundamental knowledge is the failure of many clinicians to recognize the significance of the change of emphasis of the BPD criteria in DSM-IV, especially those characteristics in what has only recently come to be known as the identity cluster within the BPD category. These shortcomings would result in the failure to identify many clients as borderline.

Research question #3 asked: How would co-dependent persons score on a BPD test instrument? The co-dependent persons in this study scored consistently higher on the BSI than the normal group scored in the 1980 study and within 5 percentage points of the BPD group in that study on 39 or 75% of the 52 items of the BSI.

A Theory

From what I have found during the course of this research, it seems that perhaps the similarities between CODC and BPD can be visualized by the schema presented in Figure 1. The range appears to extend from *normal* at one extreme, through an area of *CODC/BPD overlap*, to the other extreme which can be labeled as *severe BPD*. Another way of saying it is that it extends from *low CODC* at one extreme, through an area of *high CODC/low BPD* to the other extreme of *high BPD*.

If this is true, then perhaps at least some of the people who had been considered by some clinicians to be co-dependent are, in fact, a high-functioning subgroup who meet some of the BPD identity cluster criteria as identified by Hurt et al. (1990). Perhaps it helps to visualize it as shown here in Figure 1.

Normal	-->	**CODC/BPD overlap**	-->	**Severe BPD**
Low CODC	-->	*High CODC/Low BPD*	-->	*High BPD*

Figure 1. CODC/BPD overlap.

The far left side represents levels of nurturing and caring considered normal and desirable, which I call *Low CODC;* the center represents an area of unhealthy, extreme CODC behavior which I call *High CODC* and it overlaps an area I call *Low BPD,* which is exemplified by high-functioning BPD outpatients such as doctors, lawyers, etc.; the far right represents severe, low-functioning BPD inpatients which I call *High BPD.*

In fact, we may find that a large proportion of people who are considered codependent by practitioners in the CODC treatment field actually may be quite normal. Gravitz and Bowden (1985) state that 96% of the U.S.

population is codependent. If that is true, then according to definitions in *Webster's Dictionary* "codependent" may be synonymous with "normal."

Webster's gives this definition

> **normal**, *a.* [L. *normalis,* from *norma,* a carpenter's square, a rule.]
> 1. conforming with or constituting an accepted standard, model, or pattern; especially, corresponding to the median or average of a large group in type, appearance, achievement, function, development, etc.; natural; standard; regular.
> 6. in psychology, average in intelligence or emotional stability.
> **normal**, *n.* 1. anything normal.
> 2. the usual state, amount, degree, etc.; especially, the median or average. (*Webster's,* 1968, p. 1221)

Recommendations for Practice

1. Practicing clinicians and graduate practicum students and interns should be made aware of similarities between CODC and BPD.

2. I believe there needs to be more emphasis on the successful treatment of BPD to help counteract the negative stereotype and feeling of hopelessness that many clinicians have regarding individuals with BPD. If clinicians regard certain clients as "a pain in the neck" and dread treating them, it is hard to imagine that the clinician's attitude will not be evident to the hypersensitive BPD clients.

3. The interventions that have proven successful with BPD clients should be taught to clinicians who work with the CODC population.

4. Clinicians should be aware of the degree to which the overlap of CODC and BPD found in this study could account for the characteristics described in popular CODC books. CODC books attribute "co-dependent" characteristics to membership in a dysfunctional family, in particular one in which alcoholism is present.

5. When a client presents himself or herself for therapy with the explanation "I am co-dependent," the clinician might consider a diagnosis of BPD.

Recommendations for Research

1. Since there appears to be overlap of the characteristics of BPD and CODC, it would be helpful to identify the most effective interventions for the various places along the area of overlap.

2. Research should be done on the extent of the overlap. It may be a continuum. At the "serious" end of the continuum CODC might be very close to BPD, but at the "mild" end it may be more akin to a concept like self-esteem than to a psychological disorder.

3. It would be interesting to do detailed research on the discriminating items of the BSI with regard to BPD and CODC. If the discriminating items could be fashioned into a brief screening instrument, this would be a valuable contribution.

4. Because the sample used in my client survey may

be unique to this geographic area, I hope client survey research will be done using the BSI with co-dependent persons in other cultural, economic, and geographic areas.

APPENDICES

APPENDIX A

PROPOSED CRITERIA FOR CO-DEPENDENT PERSONALITY DISORDER

APPENDIX A

PROPOSED CRITERIA FOR CO-DEPENDENT PERSONALITY DISORDER

(Proposed by Timmen L. Cermak, M.D.)

A. Continued investment of self-esteem in the ability to control both oneself and others in the face of serious adverse consequences.

B. Assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own.

C. Anxiety and boundary distortions around intimacy and separation.

D. Enmeshment in relationships with personality disordered, chemically dependent, other co-dependent, and/or impulse disordered individuals.

E. Three or more of the following:

1. Excessive reliance on denial
2. Constriction of emotions (with or without dramatic outbursts)
3. Depression
4. Hypervigilance
5. Compulsions
6. Anxiety
7. Substance abuse

8. Has been (or is) the victim of recurrent physical or sexual abuse

9. Stress-related medical illnesses

10. Has remained in a primary relationship with an active substance abuser for at least two years without seeking outside help

APPENDIX B

DSM-III-R CRITERIA FOR BORDERLINE PERSONALITY DISORDER

APPENDIX B

DSM-III-R CRITERIA FOR BORDERLINE PERSONALITY DISORDER

DSM-III-R defines borderline personality disorder as,

A pervasive pattern of instability of mood, interpersonal relationships, and self-image, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

(1) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of over idealization and devaluation

(2) impulsiveness in at least two areas that are potentially self-damaging, e.g., spending, sex, substance use, shoplifting, reckless driving, binge eating (Do not include suicidal or self-mutilating behavior covered in [5].)

(3) affective instability: marked shifts from baseline mood to depression, irritability, or anxiety, usually lasting a few hours and only rarely more than a few days

(4) inappropriate, intense anger or lack of control of anger, e.g., frequent displays of temper, constant anger,

recurrent physical fights

(5) recurrent suicidal threats, gestures, or behavior, or self-mutilating behavior

(6) marked and persistent identity disturbance manifested by uncertainty about at least two of the following: self-image, sexual orientation, long-term goals or career choice, type of friends desired, preferred values

(7) chronic feelings of emptiness or boredom

(8) frantic efforts to avoid real or imagined abandonment (Do not include suicidal or self-mutilating behavior covered in [5].) (American Psychiatric Association, 1987, p. 347).

APPENDIX C

DSM-IV CRITERIA FOR BORDERLINE PERSONALITY DISORDER

APPENDIX C

DSM-IV CRITERIA FOR BORDERLINE PERSONALITY DISORDER

DSM-IV defines borderline personality disorder as, A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance use, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.

(5) recurrent suicidal behavior, gestures, or threats, or

self-mutilating behavior

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms (American Psychiatric Association, 1994, p. 654).

APPENDIX D

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

APPENDIX D

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our

conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs. (Al-Anon Family Group Headquarters, Inc. [Al-Anon Family Groups], 1988, 368-369)

APPENDIX E

TWO SURVEY INSTRUMENTS

AND RELATED CORRESPONDENCE

AND FORMS FOR DOCTORAL DISSERTATION

ANDREWS
UNIVERSITY

July 25, 1995

Helen P. Bird
P. O. Box 17224
Red Bank TN 37415

Dear Helen:

On behalf of the Human Subjects Review Board (HSRB) I want to advise you that your proposal, "A Theory on the Relationship Between Co-dependence and Borderline Personality Disorder," has been reviewed under the Exempt Review Category. You have been given clearance to proceed with your research plans.

All changes made to the study design and/or consent form after initiation of the project require prior approval from the HSRB before such changes are implemented. Feel free to contact our office if you have any questions. The duration of the present approval is for one year. If your research is going to take more than one year, you must apply for an extension of your approval in order to be authorized to continue with this project.

Some proposals and research designs may be of such a nature that participation in the project may involve certain risks to human subjects. If your project is one of this nature and in the implementation of your project an incidence occurs which results in a research-related adverse reaction and/or physical injury, such an occurrence must be reported immediately in writing to the Human Subjects Review Board. Any project-related physical injury must also be reported immediately to the University physician, Dr. Loren Hamel, by calling (616) 473-2222.

We wish you success as you implement the research project as outlined in the approved protocol.

Sincerely,

James R. Fisher, Director
Office of Scholarly Research

c: Jim Tucker

Office of Scholarly Research, Haughey Hall, Rm. 130, (616) 471-6088
Andrews University, Berrien Springs, MI 49104-0355

Anonymous Survey

Do you ever diagnose a client as "Borderline Personality Disorder" (BPD)? __Yes __No

Do you ever treat clients for "co-dependency" (COD)? . . . . . __Yes __No

Do you think codependence should be a DSM diagnostic category? . . . . . __Yes __No

Please check the items below that you believe are characteristic of BPD, COD, or both:

	BPD	COD	
1.	____	____	They attempt to control other people and events totally
2.	____	____	They go to great lengths to avoid acknowledging or revealing their anger
3.	____	____	They are very sensitive to anything they perceive as criticism, disapproval or lack of appreciation
4.	____	____	They keep important and potentially troublesome issues out of their therapy sessions
5.	____	____	They cycle back and forth between their need to be close to their loved one and their inability to tolerate closeness once they have it
6.	____	____	In relationships they either cling or remain aloof and emotionally uninvolved out of fear of being hurt or rejected
7.	____	____	They are not able to maintain consistent commitment in relationships when they are frustrated or angry
8.	____	____	They have difficulty acknowledging any thoughts, feelings, or characteristics that violate their particular view of themselves
9.	____	____	They choose careers requiring professional detachment where they can project themselves into *other* peoples' lives and identify with *their* drama without having to commit themselves to the same emotions and activities in their *own* lives
10.	____	____	Their interests, mannerisms, values, and style of dress change as the nature of their relationships change

The following information would be very helpful:

Highest earned degree(s): _____ License or Accreditation:_____

Job title(s):_____

Where you practice: Mental health treatment facility _____
Substance abuse treatment facility _____
Other:_____

Thank you for completing this form. Helen P. Bird, P.O. Box 17224, Red Bank, TN 37415

File: disserta\survey.1

KEY to Questionnaire Categories

BPD COD

1. ____ ____ They attempt to control other people and events totally
   Control (Splitting)
   Goldstein, E. G. (1990). *Borderline disorders: Clinical models & techniques*, p. 36

2. ____ ____ They go to great lengths to avoid acknowledging or revealing their anger
   Anger and control (Splitting)
   Goldstein (1990), p. 44-7

3. ____ ____ They are very sensitive to anything they perceive as criticism, disapproval or lack of appreciation
   Self-esteem regulation
   Goldstein (1990)., p. 49

4. ____ ____ They keep important and potentially troublesome issues out of their therapy sessions
   Control and denial (Splitting)
   Goldstein (1990), p. 39

5. ____ ____ They cycle back and forth between their need to be close to their loved one and their inability to tolerate closeness once they have it
   Rollercoastering or clinging and distancing (Fear of abandonment)
   Goldstein (1990), p. 46

6. ____ ____ In relationships they either cling or remain aloof and emotionally uninvolved out of fear of being hurt or rejected
   Rollercoastering or clinging and distancing (Fear of abandonment)
   Masterson, J. F. (1988), *The search for the real self*, p. 77

7. ____ ____ They are not able to maintain consistent commitment in relationships when they are frustrated or angry
   Anger (Splitting)
   Masterson (1988), p. 78-9

8. ____ ____ They have difficulty acknowledging any thoughts, feelings, or characteristics that violate their particular view of themselves
   Perfectionism (Identity disturbances)
   Goldstein (1990), p. 31

9. ____ ____ They choose careers requiring professional detachment where they can project themselves into *other* peoples' lives and identify with *their* drama without having to commit themselves to the same emotions and activities in their *own* lives
   Intellectualizing (Identity disturbances)
   Masterson (1988), p. 87

10. ____ ____ Their interests, mannerisms, values, and style of dress change as the nature of their relationships change
    External referenting (Identity disturbances)
    Goldstein (1990), p. 31

ALBERT EINSTEIN COLLEGE OF MEDICINE
OF YESHIVA UNIVERSITY

1300 MORRIS PARK AVENUE, BRONX, NEW YORK 10461 • CABLE EINCOLLMED, N.Y.

DEPARTMENT OF PSYCHIATRY

Mailing Address
Bronx Municipal Hospital Center
Pelham Parkway South & Eastchester Road
Bronx, New York 10461

October 17, 1995

Ms. Helen P. Bird
P. O. Box 2358
Hazard, Kentucky 41702

Dear Ms. Bird:

Thank you for your interest in the Borderline Syndrome Index. You are welcome to duplicate the questionnaire and use it for clinical or research purposes at no cost.

I am enclosing articles that describe two other studies in which it was used, as well as the BSI itself and the original 1980 article.

If there is any additional information I can give you, please do not hesitate to write or phone me (718) 918-3751. I would most appreciate knowing of any results that you obtain with the BSI.

Sincerely,

Hope R. Conte

Hope R. Conte, Ph.D.
Professor of Psychiatry

HRC:lo
Enc.

ANDREWS
UNIVERSITY

December 13, 1995

Helen Bird
P.O. Box 2358
Hazard KY 41702

Dear Helen:

On behalf of the Human Subjects Review Board (HSRB) I want to advise you that your proposal, "A Theory on the Relationship Between Co-dependence and Borderline Personality Disorder," has been reviewed under the Exempt Review Category. You have been given clearance to proceed with your research plans*.

All changes made to the study design and/or consent form after initiation of the project require prior approval from the HSRB before such changes are implemented. Feel free to contact our office if you have any questions. The duration of the present approval is for one year. If your research is going to take more than one year, you must apply for an extension of your approval in order to be authorized to continue with this project.

Some proposals and research designs may be of such a nature that participation in the project may involve certain risks to human subjects. If your project is one of this nature and in the implementation of your project an incidence occurs which results in a research-related adverse reaction and/or physical injury, such an occurrence must be reported immediately in writing to the Human Subjects Review Board. Any project-related physical injury must also be reported immediately to the University physician, Dr. Loren Hamel, by calling (616) 473-2222.

We wish you success as you implement the research project as outlined in the approved protocol.

Sincerely,

J.R. Fisher

James R. Fisher, Director
Office of Scholarly Research

c: J. Tucker

* Thank you for submitting a copy of the cover letter which is to accompany the data collection instrument and which will explain the issue of implied informed consent by the return of the anonymous questionnaire and other consent issues. Received 12/18/95

Office of Scholarly Research, Haughey Hall, Rm. 130, (616) 471-6088
Andrews University, Berrien Springs, MI 49104-0355

Anonymous Personality Style Inventory

Please indicate whether each of the following statements describe the way you feel or act.

ITEM		YES	NO
1. I never feel as if I belong	1.	___	___
2. I am afraid of going crazy.	2.	___	___
3. I want to hurt myself.	3.	___	___
4. I am afraid to form a close personal relationship.	4.	___	___
5. People who seem great at first often turn out to disappoint me.	5.	___	___
6. People disappoint me.	6.	___	___
7. I feel as if I can't cope with life.	7.	___	___
8. It seems a long time since I felt happy.	8.	___	___
9. I feel empty inside.	9.	___	___
10. I feel my life is out of control.	10.	___	___
11. I feel lonesome most of the time.	11.	___	___
12. I turned out to be a different kind of person than I wanted to be.	12.	___	___
13. I am afraid of anything new.	13.	___	___
14. I have trouble remembering things.	14.	___	___
15. It's hard for me to make decisions.	15.	___	___
16. I feel there is a wall around me.	16.	___	___
17. I get puzzled as to who I am.	17.	___	___
18. I am afraid of the future.	18.	___	___
19. Sometimes I feel I'm falling apart.	19.	___	___
20. I worry that I will faint in public.	20.	___	___
21. I never accomplish as much as I could.	21.	___	___
22. I feel as if I were watching myself play a role.	22.	___	___
23. My family would be better off without me.	23.	___	___
24. I am beginning to think that I'm losing out everywhere.	24.	___	___
25. I can't tell what I will do next.	25.	___	___
26. When I get into a relationship, I feel trapped.	26.	___	___
27. No one loves me.	27.	___	___
28. I can't tell the difference between what has really happened and what I have imagined.	28.	___	___
29. People treat me like "a thing."	29.	___	___
30. Sometimes strange thoughts come into my head, and I can't get rid of them.	30.	___	___
31. I feel life is hopeless.	31.	___	___
32. I have no respect for myself.	32.	___	___
33. I seem to live in a fog.	33.	___	___
34. I am a failure.	34.	___	___
35. It scares me to take responsibility for anyone.	35.	___	___
36. I do not feel needed.	36.	___	___
37. I don't have any real friends.	37.	___	___
38. I feel that I can't run my own life.	38.	___	___
39. I feel uneasy in crowds, such as when I'm shopping or at a movie.	39.	___	___
40. I have trouble making friends.	40.	___	___
41. It's too late to try to be somebody.	41.	___	___
42. It's hard for me just to sit still and relax.	42.	___	___
43. I feel as if other people can read me like an open book.	43.	___	___
44. I feel as if something is about to happen.	44.	___	___
45. I am bothered by murderous ideas.	45.	___	___
46. I don't feel sure of my masculinity (femininity).	46.	___	___
47. I have trouble keeping friends.	47.	___	___
48. I hate myself.	48.	___	___
49. I often have sex with persons I don't care for.	49.	___	___
50. I feel afraid in open spaces or on the street.	50.	___	___
51. I sometimes keep talking to convince myself that I exist.	51.	___	___
52. Sometimes I am not myself.	52.	___	___

(OVER)

1. Do you describe yourself as "co-dependent?"

___ Yes

___ No

2. Have other people told you that you are "co-dependent?"

___ Yes; if so, who? ___ counselor, ___ relative, ___ friend, ___ other: _____

___ No

3. Do you read self-help co-dependence literature?

___ A lot

___ A little

___ No

4. Have you ever attended support groups such as Al-Anon or CoDA?

___ Yes; for how long? _____ months, or _____ years

___ No

5. Have you ever been treated for co-dependence by a substance abuse or mental health professional?

___ Yes; for how long? _____ months, or _____ years

___ No

6. Education: Please indicate your highest earned degree(s)

___ Did not complete high school or receive GED

___ Completed high school or received GED

___ College graduate with _____ degree

___ Completed graduate school with _____ degree(s)

7. Occupation: _____

8. Where you completed this form:

___ Substance abuse treatment facility

___ Mental health treatment facility

___ Al-Anon or CoDA meeting

___ Other

Thank you for completing the survey on the other side of this page

(OVER)

Helen P. Bird
P. O. Box 2358
Hazard, KY 41702

Phone: AC 606, 439-1204
E-mail: helenbird@aol.com

December 15, 1995

Kentucky River Community Care
115 Rockwood Lane
Daniel Boone Parkway
Hazard, KY 41701

To whom it may concern:

My doctoral dissertation in counseling psychology at Andrews University in Berrien Springs, MI deals in part with "co-dependence." As part of my research I would like to have the enclosed Anonymous Personality Style Inventory (APSI) completed by persons who identify themselves as co-dependent or who are considered to be co-dependent by someone else, such as a relative, a friend, or a counselor who works with that population. This instrument is appropriate for use at a treatment center or at ACOA, Al-Anon or CoDA meetings. The decision to complete the instrument is voluntary and the client is totally anonymous. Therefore, the APSI has been placed in the Exempt Review category by the Andrews University Human Subjects Review Board.

It takes the client only a few minutes to answer the 8 demographic questions on the back and to check "yes" or "no" on the 52 questions of the instrument itself. There is no treatment involved, and minimal staff time is required. A clerk or intake worker can hand out the forms and collect and place them in a self-addressed stamped envelope to be mailed to me.

Is there a point during your intake or treatment process when this opportunity might be offered to appropriate individuals? I will be happy to provide the forms in any amount you wish along with a supply of self-addressed stamped envelopes. If you have questions about this project please feel free to contact the Chair of my dissertation committee, James A. Tucker, Ph.D., Professor, Educational and Counseling Psychology; phone AC 616, 471-3475.

If this is feasible please let me know how to proceed in obtaining permission.

Sincerely,

Helen P. Bird, M.A.
Psychological Associate (Temp.)

cc: Dr. Tucker

Helen P. Bird
P. O. Box 2358
Hazard, KY 41702

Phone: AC 606, 436-5761

January 1996

Dear Research Participant:

My doctoral dissertation in counseling psychology deals in part with "co-dependence." As part of my research I would like to know how co-dependent persons perceive and describe themselves. To gather this information I need to have copies of the enclosed Anonymous Personality Style Inventory (APSI) completed by persons who identify themselves as co-dependent or who are considered to be co-dependent by someone else, such as a relative, a friend, or a counselor. The decision to complete the form is voluntary and the client is totally anonymous. Therefore, the APSI has been placed in the Exempt Review category by the Andrews University Human Subjects Review Board.

I appreciate your willingness to volunteer to spend the few minutes it takes to answer the 8 questions on the back and to check "yes" or "no" on the 52 questions of the survey itself. There is no form of treatment involved. A staff member hands out the forms and then collects the completed ones and places them in a self-addressed stamped envelope to be mailed to me to be scored and tabulated. Your anonymity is guaranteed because I do not know the names of anyone who is taking it.

If you have questions about this project please feel free to contact me or the Chair of my dissertation committee, James A. Tucker, Ph.D., Professor, Educational and Counseling Psychology, Bell Hall, Andrews University, Berrien Springs, MI 49104; phone AC 616, 471-3475.

Thank you again for volunteering to participate.

Sincerely,

Helen P. Bird, M.A.
Psychological Associate (Temp.)

cc: Dr. Tucker

Helen P. Bird
P. O. Box 2358
Hazard, KY 41702

Phone: AC 606, 436-5761

December 19, 1995

ACOA, Al-Anon, or CoDA Group

To whom it may concern:

My doctoral dissertation in counseling psychology at Andrews University in Berrien Springs, MI deals in part with "co-dependence." As part of my research I would like to have the enclosed Anonymous Personality Style Inventory (APSI) completed by persons who identify themselves as co-dependent or who are considered to be co-dependent by someone else, such as a relative, a friend, or a counselor who works with that population. This instrument is appropriate for use at ACOA, Al-Anon or CoDA meetings. The decision to complete the instrument is voluntary and the person is totally anonymous. Therefore, the APSI has been placed in the Exempt Review category by the Andrews University Human Subjects Review Board.

It takes the person only a few minutes to answer the 8 demographic questions on the back and to check "yes" or "no" on the 52 questions of the instrument itself. Anyone can hand out the forms and collect and place them in the enclosed self-addressed stamped envelope to be mailed to me. The person who chooses to complete the form keeps the letter addressed to "Research Participant" in case they wish to obtain more information on the project.

I will be happy to supply more forms if you need them, along with more self-addressed stamped envelopes. If you have questions about this project please feel free to contact me or the Chair of my dissertation committee, James A. Tucker, Ph.D., Professor, Educational and Counseling Psychology at Andrews University in Berrien Springs, Michigan; phone AC 616, 471-3475.

Sincerely,

Helen P. Bird, M.A.
Psychological Associate (Temp.)

cc: Dr. Tucker

TABLE 2

Conversion Table of Raw Scores to Percentile Scores on the Borderline Syndrome Index for Borderline Patients and Normal Subjects

Raw Scores	Percentiles	
	Borderline	Normals
0	0	5
1	0	20
2	0	34
3	0	44
4	1	54
5	1	60
6	1	67
7	2	72
8	2	77
9	3	81
10	3	83
11	4	87
12	4	89
13	5	91
14	7	93
15	8	94
16	10	95
17	14	96
18	15	97
19	18	97
20	23	98
21	28	98
22	33	99
23	38	99
24	45	99
25	51	100
26	56	
27	62	
28	67	
29	71	
30	75	
31	80	
32	82	
33	85	
34	87	
35	88	
36	90	
37	92	
38	93	
39	94	
40	95	
41	96	
42	97	
43	98	
44	98	
46	98	
46	96	
47	99	
48	99	
49	99	
50+	100	

TABLE 1

Per Cent Endorsement of BSI Items by Individuals in Each Diagnostic Category

	Item	Borderline (*N* = 35)	Depressed (*N* = 36)	Schizophrenics (*N* = 20)	Normals (*N* = 50)
		%	%	%	%
1.	I never feel as if I belong.	69	39	25	8
2.	I am afraid of going crazy	63	31	25	12
3	I want to hurt myself.	40	0	15	0
4.	I am afraid to form a close personal relationship.	60	19	25	12
5.	People who seem great at first often turn out to disappoint me.	69	33	40	40
6	People disappoint me.	74	39	65	52
7	I feel as if I can't cope with life	77	58	35	4
8	It seems a long time since I felt happy.	80	75	45	14
9.	I feel empty inside.	69	61	30	6
10.	I feel my life is out of control.	60	64	25	2
11.	I feel lonesome most of the time.	80	67	45	14
12.	I turned out to be a different kind of person than I wanted to be.	74	75	55	18
13.	I am afraid of anything new.	43	36	25	8
14.	I have trouble remembering things.	60	56	25	18
15.	It's hard for me to make decisions.	71	69	45	28
16.	I feel there is a wall around me.	46	50	20	8
17.	I get puzzled as to who I am.	46	36	35	18
18	I am afraid of the future.	60	61	40	22
19.	Sometimes I feel I'm falling apart.	80	78	40	32
20.	I worry that I will faint in public.	14	17	5	4
21.	I never accomplish as much as I could.	86	61	50	46
22.	I feel as if I were watching myself play a role.	52	19	50	6
23.	My family would be better off without me.	51	25	35	0
24.	I am beginning to think that I'm losing out everywhere.	66	39	50	8
25.	I can't tell what I will do next.	54	22	35	10
26.	When I get into a relationship, I feel trapped.	46	14	40	16
27.	No one loves me.	26	8	20	2
28.	I can't tell the difference between what has really happened and what I have imagined.	29	6	25	4
29.	People treat me like "a thing."	26	3	30	6
30.	Sometimes strange thoughts come into my head, and I can't get rid of them.	63	39	40	32
31.	I feel life is hopeless.	49	44	40	0
32.	I have no respect for myself.	46	31	35	2
33.	I seem to live in a fog.	57	44	35	4
34.	I am a failure.	51	25	30	4
35.	It scares me to take responsibility for anyone.	49	29	40	10
36.	I do not feel needed.	43	39	25	14
37	I don't have any real friends.	26	39	35	0
38.	I feel that I can't run my own life.	43	50	25	8
39.	I feel uneasy in crowds, such as when I'm shopping or at a movie.	34	33	45	8
40.	I have trouble making friends.	37	14	25	6
41.	It's too late to try to be somebody.	37	31	25	4
42.	It's hard for me just to sit still and relax.	71	69	60	36
43.	I feel as if other people can read me like an open book.	46	19	45	8
44.	I feel as if something is about to happen.	49	42	45	22
45.	I am bothered by murderous ideas.	26	11	25	4
46.	I don't feel sure of my masculinity (femininity).	31	17	25	10
47.	I have trouble keeping friends.	34	11	25	8
48.	I hate myself.	37	33	20	6
49.	I often have sex with persons I don't care for.	17	6	20	4
50.	I feel afraid in open spaces or on the streets.	17	11	20	4
51.	I sometimes keep talking to convince myself that I exist.	37	22	30	2
52	Sometimes I am not myself.	74	53	60	28

APPENDIX 5

PERCENT ENDORSEMENT OF BSI ITEMS BY CODC, BPD, & NORMALS

Bold + asterisk (*) = Items where CODC was = or > BPD

Bold = Items where CODC group was within 5% of BPD

		CODC (*N* = 44)	BPD (*N* = 35)	Normals (*N* = 50)
		%	%	%
1.		59	69	8
2.	*	73	63	12
3.		25	40	0
4.	*	68	60	12
5.	*	73	69	40
6.		70	74	52
7.		68	77	4
8.		70	80	14
9.	*	77	69	6
10.	*	64	60	2
11.	*	80	80	14
12.		73	74	18
13.	*	52	43	8
14.	*	66	60	18
15.		57	71	28
16.	*	68	46	8
17.	*	61	46	18
18.	*	68	60	22
19.		75	80	32
20.	*	27	14	4
21.		70	86	46
22.	*	57	52	6
23.		30	51	0
24.		48	66	8
25.		45	54	10
26.	*	55	46	16
27.		25	26	2
28.		25	29	4
29.	*	41	26	6
30.		48	63	32
31.		48	49	0
32.		39	46	2
33.		52	57	4
34.		41	51	4
35.		48	49	10
36.	*	50	43	14
37.	*	45	26	0
38.	*	57	43	8
39.	*	64	34	8
40.		34	37	6
41.		34	37	4
42.		70	71	36
43.	*	52	46	8
44.	*	70	49	22
45.	*	27	26	4
46.	*	34	31	10
47.		30	34	8
48.		36	37	6
49.		7	17	4
50.	*	48	17	4
51.		36	37	2
52.		73	74	38

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VITA:

Helen P. Bird
P. O. Box 2358
Hazard, KY 41702

EDUCATION

1996	Ph.D.	Counseling Psychology, Andrews University, Berrien Springs, MI
1992	M.A.	Community Counseling, Andrews University, Berrien Springs, MI
1985	M.A.	Communication, Regent University, Virginia Beach, VA
1955	B.A.	Psychology, Wilson College, Chambersburg, PA

PROFESSIONAL EXPERIENCE

1995:	*Adult Mental Health Therapist, Kentucky River Community Care, Hazard, KY*
1995:	*Psychological Test Coordinator, Greenleaf Outpatient Center, Chattanooga, TN*
1994-1995:	*Psychological Examiner, Fortwood Center, Inc., Chattanooga, TN*
1993-1994:	*Predoctoral Internship, Northwest Georgia Consortium, Rome & Dalton, GA*
1993:	*Mental Health Technician, Madison Center, South Bend, IN*
1992-1993:	*Leader, Outpatient Group, Kingwood Hospital, Michigan City, IN*
1990-1993:	*3,126 hour Practicum, Andrews University Psychological Services Center, and Alternatives Counseling Center, South Bend, IN*

LICENSE, MEMBERSHIPS, & PRESENTATION

Psychological Associate, KY
American Psychological Association, Student Affiliate
Kentucky Psychological Association, Member
Presenter, Association for Counselor Education & Supervision, Chicago, IL, 1991

PARTIAL LIST OF PREVIOUS WORK & CIVIC ACTIVITIES

1987-89	Director of Communications, The Troyer Group, Mishawaka, IN
1985-87	News Researcher & Media Communications Consultant, Washington DC
1982-85	Studying for M.A. in Communication, Virginia Beach, VA
1980	Board of Directors, Solar Energy Industries Assoc., Washington D.C.
1978	Board of Directors, National Intervenors, Washington, D.C.
1975-80	Listed in *Who's Who of American Women*
1974-82	Community College Instructor, Asheville, & Hendersonville, NC
1974-82	Owner of a Solar Energy education and training firm
1971-74	Consultant, SE Environmental Services, Jacksonville, FL
1970-75	President, SE Environmental Council, Inc., Jacksonville, FL
1970-73	Regional Vice President, Florida Wildlife Federation
1970	Governor's Award, Outstanding Conservationist of the Year (Florida)
1969-70	Woman of the Year for Conservation, Jacksonville, Florida
1969	President's Citation, Florida Federation of Garden Clubs
1966-67	Coordinator, Florida Citizens for Clean Water
1965-66	Conservation Chairman, Florida Audubon Society
1965	Conservation Chairman, Orange Audubon Society, Winter Park, FL